



Injury/Accident Investigation & Witness Statement

(To be completed by IES or representative at client company)

INJURED WORKER _____ DATE OF INJURY _____

NAME OF WITNESS _____ DEPT. _____

WERE YOU IN THE AREA WHERE ACCIDENT HAPPENED? YES ___ NO ___
WHERE EXACTLY DID THE ACCIDENT HAPPEN? _____

DID YOU SEE THE ACCIDENT HAPPEN? YES ___ NO ___
WHAT EXACTLY DID HAPPEN? _____

WAS IT OBVIOUS THAT THE EMPLOYEE WAS HURT? YES ___ NO ___
WHAT PART OF BODY WAS INJURED? (BE SPECIFIC) _____

WAS THE EMPLOYEE USING A TOOL OR PIECE OF MACHINERY WHEN INJURED? PLEASE DESCRIBE. YES ___ NO ___

HAVE YOU EVER HEARD EMPLOYEE COMPLAIN OF SIMILAR INJURY OR ILLNESS? YES ___ NO ___

HAVE YOU EVER HEARD EMPLOYEE TALK ABOUT AN ON-THE-JOB INJURY OR ILLNESS BEFORE? YES ___ NO ___

ARE YOU AWARE OF ANY OTHER ACCIDENTS, PERSONAL OR ON-THE-JOB, THIS EMPLOYEE HAS HAD? IF SO, DESCRIBE? YES ___ NO ___

DID THE EMPLOYEE VIOLATE A KNOWN SAFETY RULE? YES ___ NO ___

DID YOU KNOW FOR A FACT THAT THE EMPLOYEE WAS AWARE OF SAFETY RULES? YES ___ NO ___

DO YOU KNOW IF THE EMPLOYEE WAS EVER CAUTIONED BY A FOREMAN OR ANYONE ELSE ABOUT UNSAFE WORK HABITS? YES ___ NO ___

WHAT DO YOU THINK CAUSED THE ACCIDENT?

- | | |
|--|--|
| <input type="checkbox"/> Unguarded equipment | <input type="checkbox"/> Non-employee |
| <input type="checkbox"/> Poorly maintained equipment | <input type="checkbox"/> Horseplay |
| <input type="checkbox"/> Deliberate violation of safety rule | <input type="checkbox"/> Another employee |
| <input type="checkbox"/> Employee carelessness | <input type="checkbox"/> Pressure to work faster |

WHAT CAN BE DONE TO PREVENT A SIMILAR ACCIDENT IN THE FUTURE? _____

COMMENTS: _____

TO THE BEST OF MY KNOWLEDGE THE ABOVE QUESTIONS ARE ANSWERED TRUTHFULLY.

SWORN TO ME THIS _____ DAY OF _____ 19____.

Witness Signature

Client Supervisor

Date

Innovative Representative

Date

No witness to this injury according to employee.

SWORN ON _____ TO _____
Date Innovative Representative

Employee Signature

Date

Innovative Employee Solutions
9665 Granite Ridge Dr. # 420
San Diego, CA 92123
858/715-5100 858/715-5110 FAX



Clinic Accident Injury Report

(Please print or type)

CLIENT: _____ DIVISION: _____

Location of plant or place where accident occurred. (Address & city) _____

Did accident occur on employer's premises? Yes ___ No ___ Department _____

County/State/Zip _____ Department regularly employed in? _____

INJURED EMPLOYEE: _____ SOCIAL SECURITY #: _____

First, Middle Initial, Last

Date of Injury: _____ Day of week: _____ Hour _____ AM _____ PM

Complete address: _____

Telephone #: _____ Phone # of Friend or Relative: _____ English spoken? _____

Age: _____ Male ___ Female ___ Marital Status _____ #Minor Children _____

First day unable to work: _____ AM _____ PM Was injured employee paid for a full day? _____

Occupation when injured: _____ Was this employee's regular occupation? Yes ___ No ___

Piece worker? Yes ___ No ___ Wages per hours \$ _____

Machine, tool or object causing injury: _____

Part of machine on which accident occurred: _____

Name the safety appliance or regulation provided: _____ Was it in use at the time? Yes ___ No ___

Describe how the accident occurred, and state what the employee was doing when injured: _____

Name(s) & Address(es) of witnesses: _____

Describe the injury in detail and indicate the part of body affected: _____

Probable length of disability: _____

Name & Address of physician (if known): _____

Name & Address of hospital (if known): _____

I hereby authorize any hospital or physician to release all information to Innovative Employee Solutions with respect to my work-related injury.

Signature of Injured Employee _____

_____ Date

Report completed by: _____

Innovative Employee Solutions
9665 Granite Ridge Dr. # 420
San Diego, CA 92123
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Medical Information Release

(To be completed by employee)

I _____ (Employee) authorize Innovative Employee Solutions to request and obtain all records regarding any industrial accident or occupational disease involving myself and _____ (Client Company). This is to include doctor's reports, follow-up reports, nurse's notes, medical bills, test results, etc.

A facsimile or photocopy of this authorization shall be considered as effective and valid as the original. This release shall remain in effect until specifically rescinded by me.

Employee Signature _____

Date _____

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Acknowledgement of Available Light Duty

(To be read and signed by employee)

Dear Innovative Employee:

Innovative Employee Solutions desires to provide our injured employees with the most expedient and quality medical care for work related injuries. Innovative Employee Solutions has developed a light duty program that allows injured workers to return to work on a light duty status by making accommodations for work restrictions.

Your signature acknowledges that you understand that, based on the doctors' recommendation, you will be offered and expected to accept modified work. If the treating physician approves modified work, and there is none available at the client company, you will receive a certified letter with an offer to work in another location.

If you have any questions or concerns, please call Innovative Employee Solutions, 858/715-5100.

Employee Signature _____

Date _____

Printed Name _____

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