ARCHDIOCESE OF PORTLAND IN OREGON

EMPLOYEE ACCIDENT INVESTIGATION REPORT

Submit with Worker's Compensation Form

LOCATION INFORMATION ☐ School ☐ Church Date of Report:_____

Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

CONTACT PERSON

Name: _____ Phone: _____ Email: _____

EMPLOYEE INFORMATION

Name: _____Phone: _____ Email: _____

Address: _____ City: _____ Zip: _____

ACCIDENT INFORMATION

Location: _____ Date: _____ Time: _____ AM/PM

Nature of injury: _____

Please explain in detail what the employee was doing when the accident occurred:

_____

_____

Was the accident reviewed with the employee? ☐ Yes ☐ No

Did the employee seek medical treatment? ☐ Yes ☐ No

Did the employee lose any time from work? ☐ Yes ☐ No

If yes, Date left: _____ Date returned: _____ Estimated date of return: _____

Did the investigation identify a workplace condition or work practice that may have contributed to the accident? ☐ Yes (If yes, please explain) ☐ No

_____

_____

If yes, what safety procedures have been considered or implemented? Please explain in detail:

_____

_____

WITNESS 1

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Email: _____

WITNESS 2

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Email: _____

Form Completed By:

_____ _____ _____ _____

Name Date Phone Email

Submit to:

Archdiocese Insurance Program
Risk Management Office
2838 E. Burnside Street, Portland, Oregon 97214
503-234-5334 Fax: 503-234-2903
riskmanagement@archdpdx.org

EAR 09/17