FCCI®

WORKERS' COMPENSATION
ACCIDENT / INCIDENT INVESTIGATION REPORT

DATE REPORT COMPLETED	CARRIER		
NAME OF POLICYHOLDER			
PERSON COMPLETING REPORT/CONDUCTING INVESTIGATION			
DATE OF INCIDENT	TIME OF INCIDENT	DATE FIRST REPORTED	TIME REPORTED
NAME OF EMPLOYEE INVOLVED			
ADDRESS OF EMPLOYEE INVOLVED		CITY	STATE / ZIP
SEX ☐ Male ☐ Female	PHONE	OCCUPATION	
LOCATION OF INCIDENT (BE SPECIFIC)			
JOB BEING PERFORMED			
WAS THE PERSON PERFORMING HIS/HER REGULAR DUTIES? ☐ Yes ☐ No	PART OF BODY OR PROPERTY DAMAGED		
WITNESSES			
DESCRIPTION OF INCIDENT (BE SPECIFIC)			
DESCRIPTION OF INJURY OR DAMAGES			
IF IT WAS A FALL, DESCRIBE FLOOR / SURFACE CONDITION (WET, DRY, SMOOTH, WOOD, TILE, STEPS, ETC.)			

This document is advisory only and does not attempt to list all potential hazards or identify all possible remedial actions. You are responsible for the safety of your premises, operations, and products. FCCI Insurance Group and its affiliates and subsidiaries shall not be liable for any loss, injury, death, damage, or expense arising out of the use of this bulletin.

CAUSE OF INCIDENT			
WAS MEDICAL TREATMENT REQUIRED? ☐ Yes ☐ No	IF "YES," WHERE? (NAME OF HOSPITAL OR CLINIC)		
ADDRESS OF HOSPITAL OR CLINIC			
IS DEFECTIVE MATERIAL INVOLVED? ☐ Yes ☐ No	IF "YES," WHAT MATERIAL?		
NAME OF MANUFACTURER			
ADDRESS OF MANUFACTURER	CITY	STATE	ZIP
NAME OF DISTRIBUTOR			
ADDRESS OF DISTRIBUTOR	CITY	STATE	ZIP
LOT OR SERIAL NUMBERS			
WAS DEFECTIVE ITEM SAVED? ☐ Yes ☐ No	WHERE?		
WHAT ACTION HAS BEEN TAKEN TO PREVENT THE RECURRENCE OF THE INCIDENT?			
DATE OF CORRECTIVE ACTION			
REPORT REVIEWED BY	DATE		

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