INCIDENT INVESTIGATION REPORT

KEMI
Kentucky Employers' Mutual Insurance
making workers' comp work ®

1. Injured Employee Information

Name _____

Job Title _____

Incident Date _____

2. Time of Incident

_____ ◯ AM ◯ PM

3. Was the incident during the employee's normal work schedule?

Yes ◯ No ◯ Overtime ◯

4. Day of Week

Mon ◯ Tues ◯ Wed ◯ Thurs ◯ Fri ◯ Sat ◯ Sun ◯

5. Location

Please describe the location where the incident occured:

_____

6. Did incident occur on employers' premises?

Yes ◯ No ◯

7. Action Taken by Company

In Plant First Aid ☐
Medical Treatment ☐
Lost Work Day ☐

8. Provide an explanation of the incident. (Be specific)

9. Part of Body Affected

Head	☐	Chest	☐
Eye	☐	Lungs	☐
Ear	☐	Abdomen	☐
Neck	☐	Groin	☐
Shoulder	☐	Hips	☐
Arm	☐	Knee	☐
Elbow	☐	Leg	☐
Wrist	☐	Ankle	☐
Hand	☐	Foot	☐
Finger	☐	Toes	☐
Back	☐	Other	☐

10. Type of Incident

Overexertion ☐
Fall - Different Level ☐
Fall - Same Level ☐
Struck Against ☐
Caught Between ☐
Struck By ☐
Vehicle ☐
Electrical ☐
Extreme Temps ☐
Repetitive Motion ☐
Radiation ☐
Absorption ☐
Slip (no fall) Twist ☐

Other _____

11. Did the employee report any of the following?

- Back Strain ☐
- Sprain ☐
- Dislocation ☐
- Fracture ☐
- Contusion ☐
- Amputation ☐
- Open Wound ☐
- Burn ☐
- Asphyixia ☐
- Hearing Loss ☐
- Foreign Body ☐
- Multiple Injury ☐
- Cumulative Trauma ☐

Other _____

12. After printing, use this area to illustrate the incident. (if applicable)

13. Personal Protective Equipment (PPE) in use at the time of the incident.

14. Note any additional information or recommendations.

Employee _____

(Signature)

Date ___ / __ / _____

Completed by: _____

(Signature)

Title _____

Date ___ / __ / _____

Print Form