



## **EMPLOYEE INCIDENT INVESTIGATION REPORT**

The Employee Incident Investigation Report serves as a fact-finding tool for our Claims Department. This form can be used as evidence in litigation to possibly contest fraudulent claims if an employee makes misrepresentations. Ultimately, this can help control the cost of your facility's Workers' Compensation Insurance.

- ❖ *Please note that the second page of this form contains the Office of Workers' Compensation form LDOI-WC-1025.EE. State law requires that injured employees read and complete that section. If an employee refuses to complete the form, please notify Risk Management Services, LLC as soon as possible. In such cases Indemnity Benefits may be suspended.*

**INSTRUCTIONS:** The injured employee should fill out the Employee Incident Investigation Report as soon after an incident as possible. Once complete, the form should be emailed or faxed by the facility to:

**Risk Management Services, LLC**

**Attn: Claims Department**

**Phone: 1-800-351-7475**

**FAX: (504) 837-3156**

**PO Box 7765**

**Metairie, LA 70010-7765**

**[customerservice@rmsla.com](mailto:customerservice@rmsla.com)**

**This cover / instruction sheet is intended for facility management and should NOT be provided to the employee!**

*This document is a sample form furnished to you as a courtesy of Risk Management Services, LLC (RMS) and the Louisiana Health Care Self Insurance Fund. RMS and LHCSIF highly recommend that you consult legal counsel before implementing the enclosed document for use in your operations. Since the enclosed is a sample document, RMS & LHCSIF are not able to provide any warranties, express or implied, in regard to this documentation.*

# **EMPLOYEE INJURY / ILLNESS INVESTIGATION REPORT**

FACILITY NAME: _____			
NAME: _____			
(LAST)	(FIRST)	(MIDDLE)	
(LAST 4 DIGITS OF SOCIAL SECURITY #)			(TELEPHONE)
(HOME ADDRESS)	(CITY)	(STATE)	(ZIP)
(MAILING ADDRESS)	(CITY)	(STATE)	(ZIP)

Please answer the following questions to the best of your knowledge.

1. On what date and time did the injury / illness occur? \_\_\_\_\_

2. What part of your body was injured during the incident? It is important that you list all parts of your body injured. \_\_\_\_\_

3. Have you ever injured or had medical treatment for this part of your body prior to this incident?  
 YES     NO    If yes, please explain:

_____
_____
_____

4. Please list the exact location where the injury / illness occurred. \_\_\_\_\_

5. What work task were you performing when the injury / illness occurred? \_\_\_\_\_

6. Did you report the injury / illness to a department manager/supervisor?  YES     NO  
If yes, please state to whom you reported the injury / illness and the date it was reported to him/her:

_____
_____

7. List the name(s), address(es) and telephone number(s) of all employee(s), or other person(s), who witnessed the injury / illness.

\_\_\_\_\_

“PURSUANT TO LSA-RS 23:1208 AND 1208.1 OF THE LOUISIANA WORKERS’ COMPENSATION ACT, I UNDERSTAND THAT THE FAILURE TO ANSWER TRUTHFULLY ANY OF THE QUESTIONS ABOVE SHALL RESULT IN (1) A FINE OF NOT MORE THAN FIVE HUNDRED DOLLARS OR IMPRISONMENT FOR NOT MORE THAN TWELVE MONTHS, OR BOTH AND (2) A FORFEITURE OF COMPENSATION AND MEDICAL BENEFITS UNDER THE LOUISIANA WORKERS’ COMPENSATION ACT.”

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

EMPLOYER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Please note any additional comments on the next page.

