Accident/Injury Investigation Worksheet (AIIW) For *ALL* Injuries/Illnesses or Motor Vehicle Accidents	**Email this form to:** **Manager, Injury Compensation** **Manager, Safety** **Post Offices - Manager, Post Office Operations and Postmaster/OIC** **Plants – Plant Manager and SMDO/MDO**

Completion of this form is mandatory on ALL injury claims and MVAs. Your responsibility as a supervisor is to thoroughly investigate accidents. This will include interviewing the injured employee, interviewing witnesses, photographing and diagramming the accident scene, and re-enacting the accident where possible. Document any hazardous situations, unusual circumstances, unsafe behavior, and any inconsistencies.

Supervisors must provide all of the following information that is known on all employee injuries/illnesses and MVAs by email titled "AIIW and name of facility" to the above individuals "immediately" or "not later than close of the business day for Customer Services", end of tour for Plants."

Today's Date	Time Called In am / pm			
Employee Name (Last, First, MI)	Date and Time of Injury/Illness	SSN		
Employee's Home Phone	Position/Title (PTF City Carrier, etc)	Begin Tour	End Tour	Pay Location
Name of Unit/Facility	Unit/Facility Telephone Number	Unit/Facility FAX Number		
Date & Time Employee Notified Supervisor of Injury Date: Time:	Supervisor's name (***if different from individual emailing notification)***			

Cause of Injury/Brief Description of Accident on how, who, what, when, where, and why:

Nature of Injury (Bite, Contusion, Cuts, Strain, Sprain, etc.)					
Body Part(s) that was/were injured					
Scheduled Days off (Week of Injury):			Rotating? (Y / N)		Fixed? (Y / N)
Employee's Work Status	Full Duty (no restrictions)		Totally Disabled from Work		
	Limited Duty (has restrictions)		If partial hours per day, number of hours		
Type of Leave requested:	COP	SL	AL	LWOP	N/A

Date Returned to Work:

MEDICAL TREATMENT INFORMATION

If no medical care was requested at this time, enter "***Declined Medical Treatment***"

Emergency Room Treatment *(Y/N)* **Choice of Treating Physician *(Y/N)***

Address (Street, City, State & ZIP)

Name of Treating Physician: Treating Physician's Specialty: Staff Contact Name:

Phone Number: Fax Number: Next Appointment Date Time: (am/pm)

Did Supervisor accompany employee? (Y / N) **DIAGNOSIS:**

Did injury/illness require? (Place an **X**):				
Physical Therapy	Stitches	X-Rays	Finger Guard	
Prescription	MRI	Splint	Injections (other than Tetanus)	

Was / Will a CA1 be submitted (Y / N)	Was / Will a CA2 be submitted (Y / N)	
Work Status (Place an **X**)	Full Duty (no restrictions)	Totally Disabled from Work
	Limited Duty (has restrictions)	If partial hours per day, number of hours