INDIANA PUBLIC EMPLOYERS' PLAN, INC.

SUPERVISOR'S INCIDENT INVESTIGATION REPORT

(Please Complete All Sections)

1. Company or Location | 2. Department | 3. Date of Incident/Day of Week

4. Exact Location of Incident | 5. Time of Occurrence (am/pm) | 6. Date Reported

7. Name of Injured | 8. Occupation | 9. Body Part Affected (See Back)

10. Nature of Injury or Illness (See Back) | 11. Item Inflicting Injury/Illness | 12. Type of Accident (See Back)

13. Person With Most Control of Item 11.

14. Description of the Incident

15. Direct Causes of Incident | 16. Why Each Cause Exists

17. Actions Taken or Needed to Prevent Recurrence | 18. Date Completed

19. Investigated By | 20. Date | 21. Reviewed By | 22. Date

Please mail form to:
ipep@ipepclaims.com

Toll free: l-800-382-8837
Claims Fax: l-765-868-3310
Local: l-765-457-9161