San Joaquin Valley HOMES

(Non-Employee)
INCIDENT/ACCIDENT/INJURY INVESTIGATION REPORT FORM

Instructions

1. Report to be completed by injured party immediately.
2. Injured party must complete Part I and Department Head where injury occurred complete Part II (Dept Manager: Make 2 copies: 1 for safety/insurance and keep 1 copy for your files)
3. Forward Original to HR Dept (HR needs to notify liability insurance co, keep a copy and forward the original to the Safety Director.

***Part I* - To be Completed by the Injured Party (Or Dept Manager where accident occurred if the injured party is not able to complete)**

Injured Person's Name: ______________________

Date of Injury: ______________ Time of Injury: ______________ a.m/p.m.

Place of Injury: (Specific location) ______________________

Was this on SJV Homes Premises? ☐ Yes ☐ No If No, Stop, contact the owner or proper law enforcement

Specify the address: ______________________

Name(s) of all witness(es) to your injury: ______________________

Names of other party(s) involved: ______________________

How did the injury occur (describe what happened): ______________________

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What body part was affected: (head, arm, leg, back, etc.) ______________________

Extent of injury: ______________________

Was first aid administered: ☐ Yes ☐ No Did you require professional medical care: ☐ Yes ☐ No

If Yes, Hospital Doctor: ______________ Date of Visit: ______________

Address of Doctor/Hospital: ______________ Phone Number: ______________

Initial Treatment: ☐ None ☐ Emergency Room ☐ On Site by Employer/Med Staff ☐ Clinic/Dr ☐ Hospital

Was an overnight stay in the hospital required: ☐ Yes ☐ No

Were you off work because of this accident: ☐ Yes ☐ No If yes, 1st work day off, date: ______________

Object or activity that directly caused the injury: ______________________

Was the injury caused by a failure of machine or product: ☐ Yes ☐ No Explain: ______________

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If applicable, was safety equipment provided: ☐ Yes ☐ No

Who did you report incident/accident to: ______________________

Was safety equipment used: ☐ Yes ☐ No

How could this incident/accident have been avoided: ______________________

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Injured Party's Signature: ______________________ **Date:** ______________

(If a vehicle was involved also complete "Vehicle Accident/Collision Report" form)

Part II - ***To Be Completed by the Department Manager where accident occurred***

Person's physical condition prior to incident/accident: ☐ Apparently normal ☐ Other

If other, please explain: ________________

Did you witness the incident/accident: ☐ Yes ☐ No

Describe accident, include the machine, object or substance involved: ________________

What caused the incident/accident: ________________

What could be done to prevent injuries of this type: ________________

Corrective action taken: ________________

Department Manager Signature: ________________ **Date:** ________

Part III ***- To Be Completed by Safety Director & Safety Committee Members***

Summary of investigation: ________________

Additional Corrective action proposed: ________________

Further recommendations: ________________

Complete Date: ________________

Safety Director Signature: ________________ **Date:** ________

Committee Member Signature: ________________ **Date:** ________