

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

Instructions

- 1. Report to be completed by injured party immediately.
- 2. <u>Injured party must complete Part I</u> and Department Head where injury occurred <u>complete Part II</u> (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.

party is not able to complete)						
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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, c	ontact the owner or p	proper law enforcer	nent
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 happen	ned):					
				·		
					······································	
What body part was affected: (head, arm, leg, b	ack etc.)					
_	ick, etc.)					
Extent of injury:						<u> </u>
Was first aid administered: Yes	LNo	Did you requ	uire professional	medical care:	Yes	∐ No
If Yes, Hospital Doctor:				Date of Visit:		
Address of Doctor/Hospital:				Phone Number:		
Initial Treatment:	Emergency R	oom	On Site by Empl	oyer/Med Staff	Clinic/Dr	Hospita
Was an overnight stay in the hospital require	d:	Yes	No			
Were you off work because of this accident:		Yes	No	If yes, 1st work	day off data:	
Dbject or activity that directly caused the injury				rt yes, rst work	day on, date.	
	•					
Was the injury caused by a failure of machine o	product:		└─ Yes	LNo	Explain:	
f applicable, was safety equipment provided:						
	l	Yes	LINo			
Who did you report incident/accident to:						
Was safety equipment used: Yes	∟No					
low could this incident/accident have been avo	ided:					

Part II - To Be Completed by the Department Manager where accident occurred	
Person's physical condition prior to incident/accident: Apparantly normal	Other
If other, please explain:	
Did you witness the incident/accident:	
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:	MAYER
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:



SAN JOAQUIN VALLEY HOMES EMPLOYEE INCIDENT REPORT

Employee Name:			Project Name:	Report No.
				Report # should be Initals & Date. (ex.: LC72721)
Date Occurred:			Time:	(CX LC/2/21)
Date Reported:				or in what area of the job):
Supervisor:				
Mark All That Apply:				
Injury	Near Miss		Property Damag	ge
First Aid**	Non-Recordabl	le	Restricted Duty	
Doctor Case	Recordable		Lost Time	
Nature of injury (Descr	iption):			
Description of Incident	(Include Cause of Injury i	if applicable)		
Dood, pac. 5	(mondo oddoo o,,a, .	Ι αργιισασίο,		
			_	
Witness Name			Employee ID#	
VVIIIICOS IVAIIIC			Phone No.	
Witness Name			Employee ID#	
VVIIIIess Ivaille			Phone No.	
Employee Instructed At	bout Hazards of Job:	YES		ractices Followed: Yes
		NO		No
Procedure for Assigned	រ Task	YES	Procedure Utilize	
Work Being Performed:			19. PPE Used:	NO
Conditions/Actions Con			IN. FFE USEU.	
	talloading to motion			
Recommendations Mad	de By Review Person (Co	mmittee) Note:	: Include Responsible Per	erson & Abatement Date
22. Injured Employee's	Ot 4			
22. Injureu Employee s	Signature			
			D:	Pate:
23. Authorized Signatur	re (General Superintende	int)		
			D:	eate: