



(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): _____

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: _____

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: _____

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: _____

