

INJURY/ILLNESS INVESTIGATION REPORT

Please complete and return form within 24 hours or the next business day of injury/illness. This completed and signed form should be faxed to Research Foundation Human Resources at (408) 924 – 1457; or scanned and e-mailed to lupe.lechuga@sjsu.edu

EMPLOYEE INFORMATION

Print Employee Name (Last, First, MI) _____

Department: _____

Employment Status: Benefited Not benefited Full Time Part Time

Temporary Position regularly assigned: _____

INJURY/ILLNESS INFORMATION

Date of Incident: _____ Time of Day: _____ AM/PM Day of Week: _____

Department/Location of incident: _____

What was the injury or illness? What specific part of the body was affected? How?

What was the Employee doing just before the incident occurred? What tools, equipment, or material were being used?

How did the injury occur? Please be specific.

What object or substance directly harmed the Employee?

SJSU RESEARCH FOUNDATION
210 North 4th Street, San Jose, CA 95112

WITNESSES: (Attach written statements)

Name: _____ Position: _____ Phone: _____

Name: _____ Position: _____ Phone: _____

CONTRIBUTING FACTORS TO INJURY/ILLNESS Check all that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> Weather conditions | <input type="checkbox"/> Poor housekeeping/clutter | <input type="checkbox"/> Unsafe act |
| <input type="checkbox"/> Lack of skill/training | <input type="checkbox"/> Defective equipment/tools | <input type="checkbox"/> Poor design |
| <input type="checkbox"/> Inadequate maintenance | <input type="checkbox"/> Inadequate work space | <input type="checkbox"/> Smoke |
| <input type="checkbox"/> Inadequate planning | <input type="checkbox"/> Uneven/wet walking surface | <input type="checkbox"/> Noise |
| <input type="checkbox"/> Inadequate lighting | <input type="checkbox"/> Inadequate protective equip. | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Inadequate ventilation | <input type="checkbox"/> lack of enforcement | <input type="checkbox"/> 3 rd party |
| <input type="checkbox"/> Chemicals (Include MSDS) | <input type="checkbox"/> Staffing | <input type="checkbox"/> Dust |

TREATMENT AND FILING CLAIM (check one):

I choose to accept medical evaluation and/or appropriate treatment, and hereby file a claim for the above noted illness or injury. I will go to the appropriate medical facility that the Research Foundation has designated.

I **decline** my right to undergo medical evaluation and/or treatment offered at no cost to me, and I decline to file a Workers' Compensation claim at this time. I understand that if I should change my mind, I have one year from the date of this injury to file a Workers' Compensation Claim. I also understand that, at that future date, I must immediately notify my manager, and I will then be referred to a health facility designated by the company.

Employee Signature

Date

Manager Signature

Date