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

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 – 1409; or scanned and e-mailed to fdn-hr-group@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?

_____

_____

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WITNESSES: (Attach written statements)

Name: _____Position: _____ Phone: _____

Name: _____Position: _____ Phone: _____

CONTRIBUTING FACTORS TO INJURY/ILLNESS Check all that apply:

___Weather conditions	___Poor housekeeping/clutter	___Unsafe act
___ Lack of skill/training	___Defective equipment/tools	__ Poor design
___ Inadequate maintenance	___Inadequate work space	___Smoke
___ Inadequate planning	___Uneven/wet walking surface	___ Noise
___Inadequate lighting	___Inadequate protective equip.	____ Fatigue
___Inadequate ventilation	___ lack of enforcement	___ 3rd party
___ Chemicals (Include MSDS)	___ Staffing	___ 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. OR
- ☐ I have a Pre-designated medical provider on file with the Research Foundation.

☐ 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