

Project #: \_\_\_\_\_ Group Name \_\_\_\_\_ Homeowner \_\_\_\_\_



## INCIDENT REPORT

(This report is due no later than 24 hours after incident occurs.)

### Information on person completing the form:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Did you witness the incident?  Yes  No

### Information on the injured individual:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  M  F

Individual Injured is:  Homeowner/Occupant of home  Volunteer  Staff

How and where did the injury occur (explain fully): \_\_\_\_\_

Describe the injury: \_\_\_\_\_

Was this condition already present before you were injured?  Yes  No

When did the symptoms first appear? \_\_\_\_\_

Did you seek medical treatment?  Yes  No

If so, where and what treatment? \_\_\_\_\_

### Please list any witnesses to the injury:

Name: \_\_\_\_\_ Contact Info: \_\_\_\_\_

Name: \_\_\_\_\_ Contact Info: \_\_\_\_\_

Signature of person completing this form \_\_\_\_\_

Date \_\_\_\_\_

**CALL Rebuilding Together to report incident at (703) 528-1999**

**Return this form to:** Rebuilding Together-AFF, 10723 Main Street, Suite 135, Fairfax, VA 22030

Fax: (703) 528-1197 E-mail: [info@rebuildingtogether-aff.org](mailto:info@rebuildingtogether-aff.org)