|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of injured person:** |  |  | **Date of birth:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date of accident:** |  |  | **Time of accident:** |  |

**Injured persons details**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Employee** |  | **Agency staff** |  | **Contractor** |  | **Visitor** |  | **Other** |  |

|  |  |
| --- | --- |
| Home address (including post code) |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Contact number: |  |  | Job role: |  |

**Details of injury (Describe the injury indicating the part and side of the body involved)**

**Where did the accident occur? (Describe the precise location and sketch if required)**

**How did the accident occur?**

**What was the injured person doing at the time of the accident?**

**Was the injured person authorised to be doing this activity?**

**Was the injured person acting safely?**

**If no, describe the unsafe action:**

**What action was taken after the accident (Was first aid treatment or a visit to the hospital required etc)**

|  |
| --- |
| **Where there any witnesses to the accident?** **If yes provide there contact details below.**Witness 1:Name:Company:Contact Number:Witness 2:Name:Company:Contact Number: |

|  |  |
| --- | --- |
| **Person reporting accident:** |  |
| **Name (Please print)** |  |
| **Job title** |  |
| **Date** |  |

|  |
| --- |
| This form along with the statements of the injured person, witnesses and the Manager must be passed immediately to Health and Safety Co-ordinator with a copy forwarded to the Safety Director.*NB: If the accident is reportable under RIDDOR Form F2508 must be completed ASAP.**Once the form , and associated documents, are completed as required by GDPR this document must be kept in a secure and safe location and handled according to people’s data protection rights.* |

#### INJURED PERSON STATEMENT

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name:** |  |  | **Date of accident:** |  |
| **Address:** |  |  | **Nature of accident:** |  |
| **Date of birth:** |  |  |  |  |

### STATEMENT

**DECLARATION OF INJURED PERSON**

I confirm that the details given above are correct.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Signed:** |  |  | **Date:** |  |

To be attached to accident report forms and passed immediately to the Health and Safety Co-ordinator.

**MANAGER’S REPORT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of injured person:** |  |  | **Date of accident:** |  |
| **Time of accident:** |  |  | **Nature of accident:** |  |
| **Name of manager:** |  |  |  |  |

### REPORT

**DECLARATION OF MANAGER**

I confirm that the details given above are correct.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Signed:** |  |  | **Date:** |  |
| **Name:** |  |  | **Job title:** |  |

To be attached to accident report forms and passed immediately to the Health and Safety Co-ordinator.

**STATEMENT OF WITNESS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Your name:** |  |  | **Date of accident:** |  |
| **Your address and contact number:** |  |  | **Nature of accident:** |  |
| **Name of injured person:** |  |  |  |  |

### STATEMENT

**DECLARATION OF WITNESS**

I confirm that the details given above are correct.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Signed:** |  |  | **Date:** |  |
| **Name:** |  |  | **Job title:** |  |

To be attached to accident report forms and passed immediately to the Health and Safety Co-ordinator.