|  |
| --- |
| **Department/Service/Functional Area** |
|  |  |
| Department: |  |
|  |
| Service: |  |
|  |
| Functional Area: |  |

|  |
| --- |
| **Accident Location (eg school, roadway, graveyard etc)** |
|  |

|  |
| --- |
| **About the person reporting the accident/incident** |
|  |  |
| Full Name: |  |  | Work Address |
|  |  |  |  |
| Occupation: |  |  |
|  |  |  |
| Contact Number: |  |  |

|  |
| --- |
| **About the injured person** |
|  |

Type of injured person (✓)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Employee |  | Contractor |  | Sub-Contractor |  | Visitor |  | Customer |  |
|  |
| Pupil |  | Unknown |  | Member of Public |  | Other |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  |  | Home Address |
|  |  |
| Employee: (✓) |  |  |
|  |
| Non – Employee: (✓) |  |  |
|  |
| Job function: |  | Gender: (✓) | Male: |  | Female |  |
|  |
| Date of Birth: |  | Telephone: |  |

|  |  |
| --- | --- |
| Check this box if the injured party gives permission for the report to be given to third parties  |  |

|  |
| --- |
| **About the incident** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| How serious was the accident/incident: (✓) | Minor |  | Serious |  | Major |  |
|  |
| Date of accident/incident: |  | What time did it happen? |  | 24hr |
|  |
| Where did the accident/incident happen: |  |
|  |
| Describe the task being carried out, any equipment being used at the time and what went wrong? |
|  |
| **Conditions at the time of the accident/incident** |

**Lighting** (✓)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Indoor…………** | Excellent |  | Poor |  | Satisfactory |  | Unknown |  |
|  |
| **Outdoor ………** | Excellent |  | Poor |  | Satisfactory |  | Unknown |  |

**Surface** (✓)

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| AstroTurf |  | Carpet |  | Concrete |  | Grass |  | Mud |  |  | Painted |  |
|  |  |
| Stones |  | Tarmac |  | Stones |  | Tiled |  | Woodchip |  |  | Wooden |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Metal |  | Vinyl flooring |  | Robber safety |  | other |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |

**Condition of surface** (✓)

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Dry |  | Wet |  | Slippery |  | Uneven |  | Unknown |  | N/a |  |

**Weather conditions** (✓)

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Fog |  | Icy |  | Raining |  | Snow |  | Sunny |  | Windy |  |
|  |
| Dull/overcast |  | Unknown |  |  |  |  |  |  |  |  |  |

|  |
| --- |
| **About any treatment given** |

|  |
| --- |
| Describe what treatment was given (if any) and by whom |
|  |

|  |  |
| --- | --- |
| How many days were lost due to this incident? |  |
|  |
| When did the injured person return to work |  / /  |
|  |
|  | **Check this box if the injured person required hospital treatment** |

|  |
| --- |
| **Part of the body injured** (✓) |
|  |







|  |
| --- |
| **What type of Personal Protective Equipment (PPE) was being worn at the time of the accident** (✓) |
|  |



|  |
| --- |
| **Cause of injury** (✓) |



|  |
| --- |
| **Effect of the accident** (✓) |
|  |



|  |
| --- |
| **Related documents** |

If you wish to attach any documents to this report, please indicate below what these documents are

|  |
| --- |
|  |

|  |
| --- |
| **Incident questions** (✓) |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Yes** **(✓)** | **No****(✓)** | **Don’t know (✓)** | **N/A** **(✓)** |
| Did the injured person continue to work after the accident/incident?  |  |  |  |  |
|  |  |  |  |  |
| Did the injured person require medical assistance or hospital treatment?  |  |  |  |  |
|  |  |  |  |  |
| Did the injured person require resuscitation?  |  |  |  |  |
|  |  |  |  |  |
| Is the injured person likely to stay in hospital for more than 24 hours? |  |  |  |  |
|  |  |  |  |  |
| Is the injury likely to prevent the person from working or carrying out their normal duties for more than 7 days? |  |  |  |  |
|  |  |  |  |  |
| Was first aid offered to the injured person?  |  |  |  |  |
|  |  |  |  |  |
| Was first aid accepted by the injured person |  |  |  |  |
|  |  |  |  |  |
| Was the injured person taken to hospital from the scene of the accident? |  |  |  |  |

|  |
| --- |
| **Witness details** |
|  |  |
| Full Name: |  |  | Address |
|  |  |  |  |
| Occupation: |  |  |
|  |  |  |
| Contact Number: |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  |  | Address |
|  |  |  |  |
| Occupation: |  |  |
|  |  |  |
| Contact Number: |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  |  | Address |
|  |  |  |  |
| Occupation: |  |  |
|  |  |  |
| Contact Number: |  |  |

**If you feel you require further support, either completing this form or following the accident please speak to your line manager.**

**Please give the completed report to your line manager under confidential cover to process and allow an investigation to take place into the circumstances of the accident.**