ACCIDENT/INCIDENT REPORT FORM

To be completed immediately an employee, contractor or “other” person is injured, unable to continue, or commence work following an injury on the premises, at a place of work or as a result of the work activity. (To include injuries such as wounds, sprains, strains, back pain, etc.) Number all pages.

Accident Book Reference Number: Scheme Ref:

Full name of person completing this report:

Date investigation requested: Date and time investigation commenced:

Location where the investigation is being carried out: (*Is it at the actual location of the incident or off site?)*

Name of Company this investigation is being carried out for:

Name and Job title of person supplying information:

TYPE OF INCIDENT (Please tick relevant boxes)

Fatality		Under “3” day injury		No time lost	
Major Injury		In hospital more than 24 hours		Member of public injured	
Over “3” day injury		Dangerous occurrence		Became unconscious	
Reportable disease		Damage incident		Needed resuscitation	

DETAILS OF THE INJURED PERSON

Name of Injured Person:

Age Sex: M/F

Status: Employee ☐ Self Employed ☐ Trainee ☐ Trade Contractor ☐ Other ☐

Injured Person’s Home Address:

Telephone Number:

Occupation when Injured:

Normal Occupation:

Years of Experience in Normal Occupation:

Nature of injury or condition, and the part of the body affected:

Company Name of Injured Person’s Employer:

THE ACCIDENT/INCIDENT

What is the exact location of the accident (attach drawings/photos where necessary):

Date and time of accident/incident:

What is the normal activity carried out at the location at the time of the accident/incident?

What job was being done by the injured person, or if not engaged directly in a work activity, what situation was the injured person in, at the time of the accident/incident?

What step of the job was in progress when the injury occurred?

Describe clearly what happened and how. Include any facts necessary to clarify what happened, e.g. weights and lengths being carried or lifted, heights & distances of slips, trips, falls, PPE etc.

Was the work being carried out in accordance with the correct method statement? Attach details:

Names, employers, employee's names and telephone numbers of witnesses (including members of the public):

What was the immediate cause of the accident/incident?

IMPROVEMENT ACTIONS - TRAINING AND RECOMMENDATIONS

What job instruction had injured person received relating to the incident, and when? or
What instruction had the employee received regarding safe methods of working and the control measures to prevent the risk of injury to persons?

What action has been taken to prevent a recurrence?

What further recommendations do you make?

Was there a Risk Assessment performed for this task?

Had the recommendations been followed?

Does the Risk Assessment need amending?

Date and time investigation completed:

SIGNATURE OF INVESTIGATOR

IT IS IMPORTANT THAT THIS FORM BE SENT TO THE DIRECTOR IN CHARGE OF HEALTH AND SAFETY AT HEAD OFFICE AS SOON AS COMPLETED.

INJURED PERSON’S STATEMENT

Full Name of Person Making this Statement: *(Please print)* ....

Statement:

Signed..

Page 1 of ....

Date.................................

Statement Continuation:

Signed.. Page…….. of ………

Date................................

WITNESS STATEMENT

Full Name of Witness: *(Please print)* ………………………………………………………………………….

Name of Employer: ……………………………………………………………………….

Contact Telephone Number: ……………………………………………………………

Statement:

Signed.. Page 1 of ………

Date.................................

Statement Continuation:

Signed... Page…….. of ………

Date................................