# YOUR COMPANY NAME

## ACCIDENT/INCIDENT REPORT FORM

To be completed immediately an employee is unable to continue, or commence work following an injury.

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| Accident Book Reference Number: | |
| Full name of person completing this report: | |
| Date investigation requested: | |
| Date and time investigation commenced: | |

**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/other contractor injured | |
| Over "3" day injury | | Dangerous occurrence | | Became unconscious | |
| Reportable disease | | Damage incident | | Needed resuscitation | |

**THE INJURED PERSON**

Name of Injured Person: Age: Sex: M/F

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/incident?

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 when they were injured:

What step of the job was in progress:

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

Names, employer's names and telephone numbers of witnesses:

What was the immediate cause of the accident/incident?

**TRAINING AND RECOMMENDATIONS**

What job instruction had injured person received relating to the incident, and when?

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What action has been taken to prevent a recurrence?

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What further recommendations do you make?

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| 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 PERSON RESPONSIBLE FOR HEALTH AND SAFETY AT HEAD OFFICE AS SOON AS COMPLETED.**

**INJURED PERSON'S STATEMENT**

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

Signed: Date:

**WITNESS STATEMENT**

Full Name of Witness: *(Please print)*

Name of Employer:

Contact Telephone Number:

Signed: Date: