

Accident and Incident Reporting Form

Personal details

Name: _____

Occupation: _____

Section/Dept: _____ Date of report: __/__/20__

Accident/incident details

Date: _____ Time: _____ Date reported: __/__/20__

Location: _____ Witness: _____

Reported to whom: _____

Full accident/incident details – what happened, or in the case of a near miss, what could have happened:

Nature of Injury:

- | | | | |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> Contusion/crush | <input type="checkbox"/> Burn | <input type="checkbox"/> Dislocation | <input type="checkbox"/> Amputation |
| <input type="checkbox"/> Laceration/open wound | <input type="checkbox"/> Superficial injury | <input type="checkbox"/> Foreign body | <input type="checkbox"/> Internal injury |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Sprain/strain | <input type="checkbox"/> Fracture | <input type="checkbox"/> Dermatitis |
| <input type="checkbox"/> Other (state): _____ | | | |

Location of Injury:

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Head/face | <input type="checkbox"/> Eye | <input type="checkbox"/> Internal organs | <input type="checkbox"/> Hand/fingers |
| <input type="checkbox"/> Shoulder/arms | <input type="checkbox"/> Trunk (other than back) | <input type="checkbox"/> Hip/leg | <input type="checkbox"/> Foot/toes |
| <input type="checkbox"/> Back | | | |
| <input type="checkbox"/> Other (state): _____ | | | |

Result of Injury:

Lost time injury: Yes No If yes, No. of days: _____ days Workers Compensation: Yes No

Treatment received: First Aid Doctor Hospital

Damage to equipment/buildings/vehicles/etc:

What was damaged?: _____

Extent of damage: _____

Contributing factors

What were the contributing factors (if any?) _____

To be completed internally:

Corrective actions

Immediate actions: _____

What controls can be put in place to prevent this from happening again? _____

Recommendations for actions: _____

Who is to implement these controls/corrective actions? _____

Date by which action is to be taken: __/__/20__

Signatures

Manager: _____ Date: __/__/20__ RTW Officer: _____ Date: __/__/20__

Director: _____ Date: __/__/20__

Actions completed: __/__/20__