Accident/Incident Report Form

Serial No:	Date:

Category *(please tick)*

Accident ☐	Physical Assault ☐	Verbal Assault ☐	Dangerous occurrence ☐	Disease ☐	Near miss ☐

Person injured/involved *(please tick, as appropriate)*

Employee ☐	Client ☐	Pupil ☐	Young person ☐	Contractor ☐	Public ☐	Other ☐

Full name and address:	If the person involved is an employee:
	Occupation:
	Works/Pay No:
Telephone No:	Service Area:
Is the person under 18? Yes ☐ No ☐	Date of birth:
Age if under 18:	Sex: Male: ☐ Female: ☐

Employee Grade: SC#4 ☐ SC5#SO2 ☐ PO1#PO6 ☐ HAY ☐ Teachers ☐ Other ☐

Accident/Incident details

Date of incident:	Time of Incident:
Accident/Incident address:	Precise location *(include Room No., area etc):*

Nature of work/activity being undertaken at the time:

Was this activity authorised? Yes ☐ No ☐

Description of Accident/Incident

Date of incident:	Time of Incident:

Describe what happened in detail *(use additional sheet(s) if necessary)*, including:
1. Name of any substance involved
2. Name and type of any machinery involved
3. The events that led to the incident
4. The part played by any person(s) (*i.e: details of assailant(s)*)

Did the accident/incident result In: Fatality ☐ Major Injury or Condition ☐ Preventing the Employee doing normal work for over three days? ☐

Non-employee being taken directly to hospital ☐ Minor injury ☐

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Details of Injury

What was the injury?	
To what part of the body?	
Was First Aid given? Yes ☐ No ☐	By whom:

Type of Accident *(please tick, as appropriate)*

Contact with moving machinery ☐	Hit by a moving, flying or falling object ☐	Hit by a moving vehicle ☐	Hit something fixed or stationery ☐
Handling, lifting, or carrying ☐	Slip, trip or fall on same level ☐	Fall from height *(please state height)* ☐	Trapped by something ☐
Drowning or asphyxiation ☐	Exposed to, or contact with harmful substance ☐	Exposed to fire ☐	Exposed to explosion ☐
Contact with ☐	Injured by an animal ☐	Assault ☐	Other *(please give details)* ☐

Person making report

Name:	Designation:
Address: Telephone No:	Date incident reported: Time incident reported:

Accident investigation *(use additional sheets if necessary)*

This section <u>MUST</u> be completed for <u>ALL</u> accidents/incidents by the injured person's line manager or Premises Controller	
What action has been taken to prevent recurrence?	Who carried out the investigation? Service: Name: Designation: Telephone No:
Were there witnesses? Yes ☐ No ☐ (*please attach statement(s)*)	Name(s): Contact No(s):

Reporting regulations 1995 (RIDDOR)

Is the injury reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)? Yes ☐ No ☐	
Has it been reported?	Date reported:

Signatures:

Injured person/parent or guardian of injured person ....

Person making report: ....

Manager/Premises controller ....