ACCIDENT REPORT FORM

FACTORY/DEPOT/PREMISES

……..

Is the injured party a Company Employee ☐ Contractor/Contractor's employee ☐ Other person ☐

If the injured person is a contractor or other person, please complete Section 2 of this form

1. EMPLOYEE DETAILS

Surname: .. …… Employee No: …….

Forenames: …… Team No: ..……...

Department: ……. Team Leader/Supervisor: ……

Male/Female: …… Job Title: ……..

Date of Birth: ……/……../…….. Date Entered Employment: ……/……/……...

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2. CONTRACTOR/OTHER PERSON DETAILS

Surname: …….. Forenames: ……...

Address: ……

……

Name of Contractor: …….

Address: ……

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Sub-Contracted to: ……

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3. DATE, TIME & PLACE OF ACCIDENT

Date of accident: ……/……../…….. Time: ……. am/pm

Where did the accident occur? ……..….

Who reported the accident? …….. To whom? ……..

Was the accident reported immediately? Yes ☐ No ☐ If NO, when was it reported? ……..

Why was it not reported immediately? …….

4. INJURY AND ATTENDANCE DETAILS (Please tick where applicable - enter R for right, L for left or B for both)

Location

Head	☐	Neck	☐	Shoulder	☐	Hip	☐	Chest	☐
Face	☐	Upper Back	☐	Upper Arm	☐	Thigh	☐	Abdomen	☐
Lower Jaw	☐	Lower Back	☐	Elbow	☐	Knee	☐	Multiple	☐
Mouth	☐	Pelvis	☐	Forearm	☐	Calf/Shin	☐		
Eye	☐			Wrist	☐	Ankle	☐		
Nose	☐			Hand	☐	Foot	☐		
				Thumb	☐	Tow	☐		
				Finger	☐				

Type

Fatality	☐	Fracture	☐	Cut	☐	Burn/Scald	☐
Amputation	☐	Strain/Sprain	☐	Dislocation	☐	Bruise	☐
Foreign Body	☐	Industrial Disease	☐	Other	☐		

(please specify) ……..

Details of Medical attention given: …….

By whom? ……...

When? ……

First Aider ☐ * Occupational Health Staff ☐ Emergency Services ☐

Other ☐ (please specify) …….

* If only minor F A treatment is needed AND a more serious injury was unlikely, do not complete the rest of this form

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5. ACTION

Return to work ☐ Hospital ☐ Sent Home ☐

Was the injured person detained in hospital for more than 24 hours? Yes ☐ No ☐

On the day of the accident, what hours was the employee:-

Expected to work From: ……. am/pm To: …… am/pm

Actually worked From: ……. am/pm To: …… am/pm

Date of first absence: ……../……/…….. Date of return to work ……./……./……...

6. KIND OF ACCIDENT AND AGENT INVOLVED

Indicate what kind of accident led to the injury or condition (tick one box)

Contact with moving machinery or material being machined ☐	Injured whilst handling lifting or carrying ☐	Trapped by something collapsing or overturning ☐	Exposure to an an explosion ☐
Struck by moving including flying or falling object ☐	Slip, trip or fall on same level ☐	Drowning or asphyxiation ☐	Contact with electricity or an electrical discharge ☐
Struck by moving vehicle ☐	Fall from height* ☐	Exposure to or contact ☐	
Struck against something fixed or stationary ☐	* Distance through which person fell (metres)		

Agent(s) involved

Indicate which, if any, of the categories of agent or factor below were involved (tick one or more of the boxes)

Machinery equipment for lifting and conveying ☐	Process plant, pipework or bulk storage ☐	Entertainment or sporting facilities or equipment ☐	Ladder or scaffolding ☐
Portable power or hand tools ☐	Any material, substance or product being used ☐	Moveable container or packaging of any kind ☐	Construction formwork, shuttering and false work ☐
Any vehicle or associated equipment/ machinery ☐	Gas vapour, dust, fume or oxygen deficient atmosphere ☐	Floor, ground, stairs or any working surface ☐	Electricity supply cable wiring, apparatus or equipment ☐
Other machinery ☐	Pathogen or infected material ☐	Building, engineering structure or excavation underground working ☐	Any other agent ☐

If Machinery Involved, please enter:-

a) Name, Type & Asset No. of Machine ……...

b) Part Causing Injury: …… c) Whether in motion at the time: Yes ☐ No ☐

If Manual Handling Involved, please enter:-

a) Approx. Weight of Object ……KGs No. of persons lifting: ONE/TWO/OVER TWO

If Access Equipment Involved (i.e. Ladder Movable Steps/Platform, Scaffolding) please enter:-

Type of Equipment: …… ……

Manufacturer (if known): …… Asset Number ……..

If a Lift/Hand Truck Involved, please enter:-

Type of Truck: …….. Asset Number ……

What protective clothing was being worn at the time of the accident? (Please tick)

Safety Shoes	☐	Gloves	☐	Mask/Respirator	☐	Wellingtons	☐
Safety Glasses	☐	Gauntlets	☐	Protective Suit	☐	Goggles	☐
Armlets	☐	Ear Defenders	☐	Face Visor	☐	Apron	☐
Hard Hat	☐	Others	☐				

Please describe the condition of the floor: ……..….

Describe what happened and how (provide a sketch/photograph and measurements where appropriate):

……..

……..

……..

……..

……..

……..

……..

Sketch

Witness: Name: ……. Employee No: ……

Name: ……. Employee No: ……

Name: ……. Employee No: ……

7. INVESTIGATION

What Preventative Measures were in place before the accident?……...

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……

What Action has or will be taken to prevent a recurrence? ……...

……

……

Date Safety Representative Informed of Accident ……../……/……

Name of person making the report: ……..

Position within the Company: …… Signature: ……

PLANT MANAGER

Are you satisfied with the accuracy of this report and any action taken? …….

……

Name: ……. Signature: ……

Injured Party

Please check that the facts recorded on this form are correct. You do not have to sign this form but if you choose to do so it will be to show that you have checked the recorded facts are correct

Signature of Injured Party: ……

Date reported to HSE (where applicable) ……..

REPORT OF AN ACCIDENT AT WORK
INITIAL SAFETY REPRESENTATIVE INFORMATION

Injured Party

Surname: …….. Forenames …….. Employee No……

Brief Accident Details: Date of Accident …./……/…… Time of Accident ……..am/pm

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8. ADDITIONAL INFORMATION