Accident and Incident Report

Use this form to report any workplace accident, injury, illness, near miss, dangerous or. A copy of this form should be retained by you. The form should be reviewed and signed by your supervisor. The original must then be forwarded to the Occupational Health and Safety Officer.

PART A: Details of the person involved in the accident or reporting the hazard

Surname: ______________________ Given Names: ______________ Date of Birth: ________ Sex: M F

Status: Management Staff: ☐ General Staff: ☐ Client: ☐ Contractor / Employed by Contractor: ☐ Visitor: ☐

Phone Number: ______________ Address: ________________________________

PART B: Details of the accident or incident

Date of accident: ______________ and Time: __________ am/pm

Where did the event happen? Be specific, e.g. group fitness room: ______________________

Describe the **accident**: task being performed, sequence of events, unexpected event, or **hazard**: the nature and seriousness of the hazard

____

____

____

________________________________ **Witness (if any)** ______________

PART C: Details of the injury / illness if any

Type(s) of injury/illness e.g. strain, cut , burn

____

____

Part(s) of the body injured: specify left/right where appropriate

____

____

Injury event: what action/exposure/event directly caused the injury/illness. **Injury agent**: What object/substance/circumstances were directly involved

____

____

____

Please note, if possible, the seriousness of injury: very low (1)> medium (3) >very high (5): ______________

PART D: Please note, if applicable, Cause(s) of Accident/Incident:

Human Error ☐	Maintenance Failure ☐	Poor Design ☐	Procedures Not Adequate ☐	Procedures Not Followed ☐	Random Event ☐	Training Not Adequate ☐	Sport Activity ☐

Other: Please specify: ________________________________

Part E: Actions recommended / taken to prevent re-occurrence or remove hazard:

Replace or repair equipment/area ☐	Improve Design ☐	Clean up ☐	Use safer alternative materials ☐	Provide training ☐	No action necessary ☐
Improve signage or markings ☐	Consult with workers ☐	Establish safe working procedure ☐	Improve or increase supervision ☐	Install safety devices ☐	

Details of action taken to prevent re-occurrence / remove hazard (and who by/when by?):

____

____

Supervisor: ______________________ Date: __________ Extension: ________

Treatments: None ☐ First Aider ☐ University Nurse ☐ Doctor ☐ Ambulance ☐ Hospital ☐ Other ☐ ______________

Outcome: Continued work/study ☐ Returned next day ☐ Absent more than 1 day ☐ Unknown ☐ Admitted to hospital? Yes ☐ No ☐

Name of the person completing this form

Name: ______________________ Date: __________ Extension: ________