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| **Person Making This Report:** |
| **Name:** |  |
| **Job title:** |  |
| **Date of report:** |  |

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| **Worksite, Where the Accident Occurred:** |
| **Worksite address:** |  |
| **Name of site contact:** |  |
| **Contact Details:** |  |
| **Job title:** |  |

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| **Accident Book:** |
| **Accident book no:** |  |
| **Reference no:** |  |
| **Date accident recorded:**  |  |

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| **Injured Person’s Personal Details:** |
| **Name:** |  |
| **Age:** |  |
| **Address:** |  |
| **National Ins. No:** |  |
| **Job Title, at Time of Accident:** |  |

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| **Injured Person’s Accident Details:** |
| **Location of accident:** |  |
| **Person’s occupation at time of their accident:** |  |
| **Date and time of accident:** |  |
| **Date & time of ceasing work (If different from above):** |  |
| **Precise nature of injuries:** |  |
| **To whom was the accident reported?** |  |
| **Date and time accident reported:** |  |
| **Was the accident reported under RIDDOR? If yes, when and how was it reported?** |  |
| **Has the accident been recorded in the official business register?** |  |
| **Was first aid given? If yes, by whom?** |  |
| **Was treatment provided by a Doctor? If yes, what was their name and contact no?** |  |
| **Did the injured person go to hospital? If yes, which hospital?** |  |

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| **Nature of the Accident:** |
| **Was the injured worker authorised to be at the place where the accident occurred, for their work?** |  |
| **What were they doing?** |  |
| **If the injured person fell from height, how many metres did they fall?** |  |
| **If machinery was connected to the accident, what was its name and or number, and what part(s) were involved?** |  |
| **Was the machine working at the time of the accident?** |  |

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| **Describe How the Accident Was Caused (Actual, or Possible Causal Factors).****If necessary, use a separate sheet of paper for a sketch plan of the scene:** |
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| **Recommended Corrective/Remedial Actions:** |
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| **If Applicable:** |
| **Other medical reports:** |  |
| **Date injured person’s employment ceased:** |  |
| **Injured person’s new address:** |  |

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| **Other:** |
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| **To be Completed by the Report Writer:** |
| **Name:** | **Signature:** | **Date Report Completed:** |
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