

**ACCIDENT REPORT – REFERENCE NO:****Person Making This Report:****Name:****Job title:****Date of report:****Worksite, Where the Accident Occurred:****Worksite address:****Name of site contact:****Contact Details:****Job title:****Accident Book:****Accident book no:****Reference no:****Date accident recorded:****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:            |  |

| Other: |
|--------|
|        |

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