ACCIDENT / INCIDENT REPORT FORM

Note:

This form should be completed whenever an accident or incident occurs which results in injury or damage to personnel or property.

If personnel or property WERE NOT injured or damaged during the Accident/ Incident, do not use this form. Use the NEAR MISS REPORT FORM.

Accident / Incident Report Form			
i	**Name of person involved in Accident/Incident:**		
ii	**Address:**		
	Phone:		
iii	**Who was involved in the Accident/Incident:** ☐ **Student** ☐ **Employee** ☐ **Public** ☐ **Contractor** ☐**Visitor**		
iv	**Occupation:**		
v	**If an employee of the Institute please state Department:**		
vi	**If no, please elaborate:**		
vii	**Particulars of Accident/Incident & circumstances under which the Accident/Incident occurred:** *Use additional pages and/or photos if necessary.*		
viii	**Place:**		
ix	**Time:**	**Date:**	
x	**Witness Phone No & Address:**		
	Witness Phone No & Address:		
xi	**When and to whom was the Accident/Incident initially reported?**		

xii	**Details of injury/damage:** Indicate type of injury (put an 'x' in one box only) ☐ Bruising, contusion ☐ Concussion ☐ Internal injuries ☐ Open wound ☐ Abrasion, graze ☐ Amputation ☐ Open fracture (i.e. bone exposed) ☐ Closed fracture ☐ Dislocation ☐ Sprain, torn ligaments ☐ Suffocation, asphyxiation ☐ Gassing ☐ Drowning ☐ Poisoning ☐ Infection ☐ Burns, scalds and frostbite ☐ Effects of radiation ☐ Electrical injury ☐ Property damage, Specify_____ ☐ Other, Specify_____
xiii	**Indicate part of body most seriously injured (put an 'x' in one box only):** ☐ Head, except eyes ☐ Eyes ☐ Neck ☐ Back, spine ☐ Chest ☐ Abdomen ☐ Shoulder, upper arm, elbow ☐ Lower arm, wrist, hand ☐ Fingers, one or more ☐ Hip joint, thigh, knee cap ☐ Knee joint, lower leg, ankle ☐ Foot ☐ Toes, one or more ☐ Extensive parts of the body ☐ Multiple injuries ☐ Other, Specify_____
xiv	**Consequences of the Accident/Incident:** Fatal ☐ Non Fatal ☐ Date of resumption of work if back Year Month Day ____ _____ ___ Anticipated absence if not back 4-7 days ☐ 8-14 days ☐ More than 14 days ☐
xv	**Treatment:**
xvi	**Doctor's report and recommendation:**
xvii	**Steps taken to prevent reoccurrence of this type of Accident/Incident:**
	Signature of person completing report: / **Date:**
	Print Name & Job Title:
	Signature of Head of Department/School/Function: / **Date:**
	Print name:

(Copies of the completed Institute Accident Report are to be sent separately to the Institute Health & Safety Co-ordinator, the Vice President for Finance & Corporate Affairs and the Estates Office)