

ACCIDENT OR INCIDENT REPORT FORM



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THIS FORM MUST BE FILLED OUT BY THE INJURED PERSON OR THE PERSON IN CHARGE, IN THE EVENT OF AN ACCIDENT (INJURY), A NEAR MISS OR AN INCIDENT INVOLVING PROPERTY LOSS OR DAMAGE (Completed forms should be forwarded to the Health and Safety Officer within 24 Hours)

What are you Reporting? (Tick X below)

Employee or Student Accident (Injury)	Near Miss (Chance alone prevented an injury)	Incident (Property loss or damage)
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Part A Please fill out if an Employee or Student was injured

Name of injured person	Student ID number where applicable
School/Department or Area of Work	Contact Details for students or visitors (Home Address & Mobile No)

Part B Please fill out for all accidents, near misses and incidents

Date of Accident	Time of Accident
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Where did the Accident/Incident take place? (Tick X below)

On Campus	Off Campus (on an approved activity)	Sports Facility on Campus
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Please tick which of the following best describes what happened

<input type="checkbox"/> Fire or release of smoke <input type="checkbox"/> Collapse or failure of a physical structure on campus <input type="checkbox"/> Contact with moving machinery or material being machined <input type="checkbox"/> Struck by a moving, flying or falling object <input type="checkbox"/> Struck by a moving vehicle <input type="checkbox"/> Trapped by something collapsed or overturning <input type="checkbox"/> Overflow, leakage or spillage of a hazardous chemical or substance <input type="checkbox"/> Contact with or exposure to a chemical or other harmful substance	<input type="checkbox"/> Slip, trip or fall on same level e.g. on a wet surface <input type="checkbox"/> Fall from a height e.g. off a footstool or ladder <input type="checkbox"/> Injured whilst lifting or carrying an object <input type="checkbox"/> Burn from a Hot Liquid or contact with a Hot surface <input type="checkbox"/> Injured by something sharp, pointed or rough <input type="checkbox"/> Collision or other involving a company vehicle <input type="checkbox"/> Contact with electricity <input type="checkbox"/> Electrical Failure	<input type="checkbox"/> Loss of control of a hand tool, handling equipment <input type="checkbox"/> Water leak or flooding <input type="checkbox"/> Physical Assault <input type="checkbox"/> Exposure to verbal or threatening behavior from an individual <input type="checkbox"/> Sports Injury <input type="checkbox"/> Occupational Ill Health (Asthma, dermatitis etc) <input type="checkbox"/> Injured by an animal <input type="checkbox"/> Other (Give details below)
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Give a Brief description of what occurred and the type of injury if sustained? What was the person doing when injured, were there others present, what factors may have contributed (Please attached any additional information which will aid an investigation, pictures etc)

If medical Treatment was given, please tick who gave the treatment (s)

N/A		First Aider		Student Health Nurse		College Doctor		Hospital	
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Part C Report Sign Off (Please sign and Date)

Injured person		Date	
Manager or Person in charge		Date	

FOR HEALTH AND SAFETY OFFICER USE ONLY

Date Received		HSA Reportable (Yes or No)	
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