Accident Report Form

THIS FORM MUST BE COMPLETED FOR ANY INJURY, WORK RELATED ILL HEALTH, DANGEROUS OCCURRENCE AND NEAR MISS IN RESPECT OF STAFF, STUDENTS, CONTRACTORS AND VISITORS

GUIDANCE

• Please complete the form in BLACK INK and in BLOCK CAPITALS.
• If you have any queries when completing this document, please ask your departmental manager for advice or contact the Health and Safety Unit on extension number 3317.
• A copy of the completed form must be passed on to the Health & Safety Unit as soon as possible.
• Keep a copy for your own record.

TO BE COMPLETED BY INJURED PERSON (IP) OR REPRESENTATIVE

SECTION 1 PERSONAL DETAILS

GUIDANCE

SECTIONS 1, 2 and 3 to be completed by the injured person where possible. Alternately a representative or manager may do so on their behalf.

Please tick as appropriate:

<table>
<thead>
<tr>
<th>Accident</th>
<th>Dangerous Occurrence</th>
<th>Work related ill health</th>
<th>Near Miss</th>
</tr>
</thead>
</table>

Full Name:

Title: Prof Dr Mr Mrs Ms

Home Address:

University Contact Number

Postcode

Job/Course Title:

Status Please Tick:

<table>
<thead>
<tr>
<th>Staff</th>
<th>Student</th>
<th>Contractor</th>
<th>Visitor</th>
</tr>
</thead>
</table>


SECTION 2  ACCIDENT RECORD

GUIDANCE
This section concerns details of the injury, work related ill health, dangerous occurrence or near miss.
Please be as specific as possible with regard to location (address, postcode, room number etc), and type of injury.
If a major injury or dangerous occurrence has occurred please contact the Health & Safety Unit as soon as possible.

When did it happen?
Date of occurrence

Where did it happen?
(state which room, bldg. or place)

How did it happen?
Give the cause if you can.

Was there an injury?
If so please give details
(e.g. fracture, bruise, cut, sprain strain)

If the person suffered work related Ill health, please give details

SECTION 3  TREATMENT DETAIL

GUIDANCE
This section should be completed by a first aider or manager/supervisor in respect for all treatment whether accepted or refused.

Was First Aid

<table>
<thead>
<tr>
<th>Accepted</th>
<th>Refused</th>
<th>Advised to attend hospital /GP</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Brief details of the First Aid given:

First Aider’s name:

Was the injured person sent to hospital:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Was the Injured Person in hospital for more than 24 hours

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hospital Details:

Signature of injured person:

Signature of Representative:

Date:(DD/MM/YY)

<table>
<thead>
<tr>
<th>/ /</th>
</tr>
</thead>
</table>

If representative, please give your full name, relationship with the injured person and contact number.

Full Name:

Contact Tel Number:

Relationship:
## SECTION 1  INVESTIGATOR DETAILS

**GUIDANCE**
To be completed by Manager/Supervisor/Lecturer. Please complete contact details in full.

<table>
<thead>
<tr>
<th>Full Name:</th>
<th>Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Faculty:</th>
<th>Extension Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>School/Dept.: Division/Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

## SECTION 2  WITNESS DETAILS

**GUIDANCE**
Please ensure that names and appropriate contact details are taken from any witnesses present. If you feel that it is necessary to add details of more than two witnesses please continue on a separate sheet and indicate that this is attached.

<table>
<thead>
<tr>
<th>First Witness</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Contact Number:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Second Witness</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Contact Number:</td>
<td></td>
</tr>
</tbody>
</table>

## SECTION 3  SAFETY MANAGEMENT CHECKLIST

**GUIDANCE**
Please ensure that all questions are answered and that copies of relevant documents are securely attached to the report/investigation forms.

- Was the area/work activity subject to a risk assessment?  
  *Yes* [ ]  *No* [ ] *(If YES, please attach a copy)*

- Have you reviewed the risk assessment in the light of the occurrence?  
  *Yes* [ ]  *No* [ ] *(If YES, please attach a copy)*

- Was Permit to Work/Access authorisation in effect?  
  *Yes* [ ]  *No* [ ] *(If YES, please attach a copy)*
Are there any departmental rules/safe systems of work applicable to the area/work activity? 
(If YES, please attach a copy)

| Yes | No |
---|---|

Was personal protective equipment being used at the time? 
(If YES, indicate the type in the boxes below)

| Eye | Face | Ear | Hand | Foot | Respiratory | Body |
---|---|---|---|---|---|---|

Has the injured person resumed work/study? 
If yes, on what date? (DD/MM/YY)

| Yes | No |
---|---|
/ /

SECTION 4 PRELIMINARY INVESTIGATION DETAILS

GUIDANCE
Please summarise accident/incident ‘cause and effect’ and action taken. Continue on a separate sheet if necessary.

Please send completed form to the Health and Safety Unit

SECTION 5
FOR USE BY HEALTH AND SAFETY UNIT

Received in Health & Safety Unit by: Ref No Date: / /

F2508 required? Further investigation required? Referral to Insurance Officer