ACCIDENT, INCIDENT & OCCUPATIONAL DISEASE REPORT FORM

Name of the person reporting the injury:			
Job title:			
Telephone number:		Alternative phone number:	

Part B	Information on Organization				
Name of the Organization:					
Location of organization	Plot No:		Name of the Building (if any)		
	Name of street/road:				
	Name of Town		Name of Region		
Nature of work					
Number of workers		Female:		Male:	

Part C	About the Incident
Type of incident (Tick applicable box)	☐ Accident resulting to injury
	☐ Near miss/dangerous occurrence
	☐ Violent incident (Physical or verbal)
	☐ Work-related ill health (Go on to Part I)
	☐ Damage to building or property

Part D	Information on the Accident		
Date of the incident		Time of the incident (24-hour):	
Did the incident happen at the Place of Work?		☐ Yes No	
If No Where did the incident happen?	☐ Elsewhere in the organization,	☐ At someone else's premises	
	In a public place		
	☐ in any other place, (please mention)		

Part E	Information on the Injured Person				
Full Name:					
Address	Plot No:		Name of the Building (if any):		
	Name of street/road:				
	Name of Town:		Name of Region:		
Trade/ Job title of the Worker					
Gender	☐ Female; ☐ Male	Age(Yrs):		Phone number:	
The injured person was (tick only one box)	☐ One of your employees		☐ On a training scheme		
	☐ On work experience		☐ Employed by someone else		
	☐ Self-employed and at work		☐ A member of the public;		
	☐ Any other, (please mention)				
Part F	About the injury				

Nature of the injury (e.g. fracture, laceration):		
Part of the body injured (e.g. leg, hand):		
Condition of the injury (Tick one box only):	☐ a fatal	☐ a major injury or condition
	☐ an over 3 day bed rest injury;	☐ become unconscious;
Injured person (Tick all the boxes that apply):	☐ required first aid treatment	☐ need resuscitation;
	☐ more than 24 hours hospitalized;	☐ none of the above

Part G	About the kind of accident	
Please tick the one box that best describes what happened	☐ Slipped tripped or fell on the same level	☐ Hit by a moving flying or falling object
	Contact with electricity or an electrical discharge	☐ Contact with moving machinery or material being machined
	☐ Hit by something fixed or stationary	☐ Exposed to or in contact with a harmful substance
	☐ Injured while handling lifting or carrying	☐ Fell from a height; Please indicate height of the fall: _____
	☐ Drowned or asphyxiated	☐ Trapped by something collapsing
	☐ Exposed to fire	☐ Hit by a moving vehicle
	☐ Injured by an animal	☐ Physically assaulted by a person
	☐ Exposed to an explosion	
	☐ Another kind of accident, please mention:	

Part H	Description of an accident
Describe (use a separate paper if necessary)	The operation(s) or activity/activities that was in progress during the accident:
	The environmental conditions at the time of accident:
	The name of substances involved (if any):
	The name and type of any machinery involved (if any):

	The events that led to the accident:
	The part played by any people to cause the accident:
	If it was a personal injury, give details of what the person was doing:
	Give any other information relevant to the incident/accident:

Part I	Occupational disease		
Type of disease:			
Date of first diagnosis or confirmation of the disease:			
Name of the doctor made diagnosis:			
Address of doctor	Building number or name:		
	Road/street name:		
	Town:	Region:	

Part J	Description of the work that led to the disease (please use a separate paper if necessary)
Please describe any work done by the affected person which might have led them getting the disease:	
If the disease is thought to have been caused by exposure to an agent at work (e.g. a specific chemical) please say what that agent is:	

Give any other information which is relevant:

Part K	Prevention measures (please use a separate paper if necessary)
Describe any measure(s) that has been taken so far to prevent a similar accident:	

Part L	Your signature
Signature:	Date:

Part M	For official use
Incident Number:	Received by: Date received: