

# 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.

<b>Please tick as appropriate:</b>	Accident <input type="checkbox"/>	Dangerous Occurrence <input type="checkbox"/>	Work related ill health <input type="checkbox"/>	Near Miss <input type="checkbox"/>	
Full Name:	<input style="width: 100%;" type="text"/>				
Title:	Prof <input type="checkbox"/>	Dr <input type="checkbox"/>	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Ms <input type="checkbox"/>
Home Address:	<input style="width: 100%; height: 100%;" type="text"/>			University Contact Number <input style="width: 100%;" type="text"/>	
				Postcode <input style="width: 100%;" type="text"/>	
Job/Course Title:	<input style="width: 100%;" type="text"/>				
Status Please Tick:	Staff <input type="checkbox"/>	Student <input type="checkbox"/>	Contractor <input type="checkbox"/>	Visitor <input type="checkbox"/>	

# 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.

<b>When did it happen?</b> Date of occurrence	DD / MM / YY <input type="text"/>	Time of occurrence: (Please use 24hr clock e.g. 0600)	Hrs : Mins <input type="text"/>
<b>Where did it happen?</b> (state which room, bldg. or place)	<input type="text"/>		
<b>How did it happen?</b> Give the cause if you can.	<input type="text"/>		
<b>Was there an injury?</b> If so please give details (e.g. fracture, bruise, cut, sprain strain)	<input type="text"/>		
If the person suffered work related ill health, please give details	<input type="text"/>		

# 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.

	Accepted	Refused	Advised to attend hospital /GP	Not Applicable
<b>Was First Aid</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brief details of the First Aid given:	<input type="text"/>			
First Aider's name:	<input type="text"/>			
Was the injured person sent to hospital:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Was the Injured Person in hospital for more than 24 hours	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hospital Details:	<input type="text"/>			
Signature of injured person:	<input type="text"/>		Signature of Representative:	<input type="text"/>
Date:(DD/MM/YY)	<input type="text"/>			
If representative, please give your full name, relationship with the injured person and contact number.				
Full Name:	<input type="text"/>		Contact Tel Number:	<input type="text"/>
Relationship:	<input type="text"/>			

# PRELIMINARY INVESTIGATION SECTION

THE DEPARTMENTAL MANAGER/SUPERVISOR/LECTURER IN CHARGE MUST COMPLETE THIS SECTION.

## SECTION 1 INVESTIGATOR DETAILS

### GUIDANCE

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

Full Name:	<input type="text"/>	Title:	<input type="text"/>
Faculty:	<input type="text"/>	Extension Number:	<input type="text"/>
School/Dept.: Division/Unit	<input type="text"/>		

## 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.

First Witness Name:	<input type="text"/>	Address:	<input type="text"/>
Contact Number:	<input type="text"/>		
Second Witness Name:	<input type="text"/>	Address:	<input type="text"/>
Contact Number:	<input type="text"/>		

## 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? (If YES, please attach a copy)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you reviewed the risk assessment in the light of the occurrence? (If YES, please attach a copy)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Was Permit to Work/Access authorisation in effect (If YES, please attach a copy)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

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)

Yes

No

Eye	Face	Ear	Hand	Foot	Respiratory	Body

Has the injured person resumed work/study?

Yes

No

If yes, on what date? (DD/MM/YY)

## 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