

Sample form for your own use (not for reporting to WorkSafe).

**ACCIDENT/INCIDENT REPORT FORM**

Record No: \_\_\_\_\_

**Personal details**

Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Section/Dept: \_\_\_\_\_ Date of report: / /

**Accident/incident details**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Date reported: / /

Location: \_\_\_\_\_ Witness: \_\_\_\_\_

Reported to whom: \_\_\_\_\_

**Full accident/incident details – what happened, or in the case of a near miss, what could have happened**

**Injury – Nature of Injury**

- |  |   |                                       |  |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> Contusion/crush       | <input type="checkbox"/> Burn               | <input type="checkbox"/> Dislocation  | <input type="checkbox"/> Amputation      |
| <input type="checkbox"/> Laceration/open wound | <input type="checkbox"/> Superficial injury | <input type="checkbox"/> Foreign body | <input type="checkbox"/> Internal injury |
| <input type="checkbox"/> Concussion            | <input type="checkbox"/> Sprain/strain      | <input type="checkbox"/> Fracture     | <input type="checkbox"/> Dermatitis      |

**Location of Injury**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Head/face     | <input type="checkbox"/> Eye           | <input type="checkbox"/> Internal organs         |
| <input type="checkbox"/> Hand/fingers  | <input type="checkbox"/> Shoulder/arms | <input type="checkbox"/> Trunk (other than back) |
| <input type="checkbox"/> Hip/leg       | <input type="checkbox"/> Foot/toes     | <input type="checkbox"/> Back                    |
| <input type="checkbox"/> Other (state) |  |  |

**Results of accident**

Lost time injury Y / N      No. of days: \_\_\_\_\_ days      Workers' compensation Y / N  
 Treatment received:       First aid       Doctor       Hospital

**Damage to equipment/buildings/vehicles etc.**

What was damaged? \_\_\_\_\_

Extent of damage: \_\_\_\_\_

**Contributing factors**

What were the contributing factors (if any)? \_\_\_\_\_

**Corrective actions**

Immediate actions \_\_\_\_\_

What controls can be put in place to prevent this from happening again? \_\_\_\_\_

Recommendations for action \_\_\_\_\_

Who is to implement these controls/corrective actions? \_\_\_\_\_

Date by which action is to be taken / /

**Signatures**

Officer: \_\_\_\_\_ HS Rep: \_\_\_\_\_ Manager: \_\_\_\_\_

Director: \_\_\_\_\_ Investigating officer: \_\_\_\_\_

Actions completed: \_\_\_\_\_ Date: / /      Manager: \_\_\_\_\_

