

S16a ACCIDENT OR INCIDENT REPORT

Last Reviewed: July 2009
Next Review: July 2010
Responsible: A. Hemmings

Injured or Affected Person

Surname:		Forename:	
Address:		Age:	Gender:
		Status:	
		Class or form if pupil:	

Details of Accident or Incident

Nature (state whether injury, near miss or other):	
Location:	
Date:	Time:
Witnesses:	

Details of Injury

Nature (if none write none):		
Part of body:		
Treatment (tick boxes):		
No treatment <input type="checkbox"/>	First aid <input type="checkbox"/>	Resumed work <input type="checkbox"/>
Sent home <input type="checkbox"/>	Attended GP <input type="checkbox"/>	Sent to hospital <input type="checkbox"/>
		Detained for _____ hours

Outcome (tick boxes)

Not off work or school <input type="checkbox"/>	Off work or school more than three days <input type="checkbox"/>	Permanent partial disability <input type="checkbox"/>
Off work or school less than three days <input type="checkbox"/>	Permanent total disability <input type="checkbox"/>	Temporary incapacity <input type="checkbox"/>

Description of Events Leading up to Accident or Incident

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Description of Immediate Actions

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Description of Possible Causes

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Review of Options to Prevent Reoccurrence

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Recommendations

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Report Completed By

Name:	Signature	Date:
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