Safety Report No:
………………….

(HSN-16) ACCIDENT / INCIDENT REPORT FORM

An accident form must be completed in the event of ALL accidents, incidents and "near-misses".

PLEASE FORWARD THE FORM IMMEDIATELY TO THE MANAGING DIRECTOR

Person Involved	Title	First name	Second name

Home / Residence Address	Site Address

Phone No.		Site Phone No.	

Male		Female		Age		Job title	

Status:	CLEANER		OTHER STAFF		CONTRACTOR		VISITOR	

Where did the accident/incident happen? (building, floor, room, etc)

When did accident happen? Date / / Time : *am/pm*

DETAILS OF THE ACCIDENT/INCIDENT

- ☐ Lifting/handling
- ☐ Ill health
- ☐ Fall from height/stairs
- ☐ Slip/trip/fall
- ☐ Contact with electricity
- ☐ Hot/cold contact
- ☐ Dangerous occurrence
- ☐ Cut with sharp object
- ☐ Near miss incident
- ☐ Needle stick
- ☐ Property loss/damage
- ☐ Fire
- ☐ Threatening behaviour
- ☐ Verbal Abuse
- ☐ Person to person assault
- ☐ Equipment failure/misuse
- ☐ Struck by/against something
- ☐ Contact/exposure to equipment/machinery
- ☐ Contact/exposure to harmful substance
- ☐ Fatality
- ☐ Other *(please specify below)*

Provide details of how the accident occurred. Use a separate sheet if necessary

Any Contributory Factors?

- ☐ Environment/ Premises
- ☐ Procedures/ Information
- ☐ Equipment/ materials
- ☐ Human factors
- ☐ Other (*please specify below)*

Nature of any injuries involved:

Provide details of injuries involved. Use a separate sheet if necessary

- ☐ Abrasion
- ☐ Fracture/dislocation
- ☐ Amputation
- ☐ Laceration
- ☐ Bruise
- ☐ Pain
- ☐ Burn/scald
- ☐ Puncture
- ☐ Crush/internal injury
- ☐ Sprain/strain
- ☐ Distress
- ☐ Swelling
- ☐ Other *(please specify in detail opposite)*

Indicate Treatment Received⇨	None Required	First aid on site	A&E at Hospital	Fi
	Visit to own GP	Admitted to Hospital		

Did person lose consciousness?		**Was person able to return to work immediately after treatment?**	

Witness Details:	Name	Name	Name
	Address	Address	Address
	Post Code	Post Code	Post Code
	Phone	Phone	Phone

Was the activity covered by Risk Assessment?

☐ Yes ☐ No ☐ N/A

Remedial Actions taken/ planned?

Has the Risk Assessment been reviewed?

☐ Yes ☐ No ☐ N/A

If the risk assessment for this activity has NOT been reviewed provide a date when it will : / /

Signature of Employee(if applicable)

OFFICE use only	Date received	Signature	Investigated By	F2508 required

FOLLOW UP REVIEW

Provide details of the review including details of compliance, non-compliance with recommendations. Use a separate sheet if necessary.

Is there full compliance with the Remedial actions?

☐ Yes ☐ No ☐ N/A

Is further investigation/ review recommended?

☐ Yes ☐ No ☐ N/A

OFFICE use only	Review Date	Signature	Print Name	Next Review Date

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