Accident Reporting Form Staff/Contractor/Visitor

Name of person(s) involved _____

_____

Accident Information

Date of Accident _____ /_____ /_____ **Time** _____
Day / Month / Year

Location: _____

Reported by: _____

What happened immediately before the event?	
What happened, describe the accident?	
What happened immediately after the event?	
Was any immediate remedial action taken?	

Hours worked since arrival:

Time lost from work: Yes ☐ No ☐

If Yes, please complete: Hours _____ Days _____

Treatment Type: First Aid ☐

Doctor ☐

Hospital ☐

No Treatment ☐

Complete this form in the event of an accident occurring and forward to the person responsible For Health and Safety in the Workplace within 5 days of the accident unless serious harm has occurred in which case the report is to be immediate.