**APPENDIX B: ACCIDENT REPORT FORM**

**INJURED PARTY DETAILS:**

|  |  |
| --- | --- |
| Surname |  |
| First Name |  |
| Address (Home) |  |
|  |
|  |
| Address (Company) |  |
|  |
|  |
| Date of Birth |  |
| Sex |  |

**STATUS:**

Employee Visitor Contractor Member of Public

Other (please specify):

Date of Accident/Incident:

Date Accident/Incident reported to management:

Where appropriate, more than one box in each section may be ticked.

**TYPE OF ACCIDENT**

Injured/damaged by a person Road Traffic Accident/Crash

Manual handling Exposure to substances/environments

Property damage Struck by/contact with

Caught in/under Slip/trip/fall

Sharps

**TYPE OF INJURY**

Fatality Bruise

Concussion Internal injury

Abrasion, graze Fracture

Sprain Torn ligaments

Burns Scalds

Frostbite Injury not ascertained

Trauma

Occupational disease

Other (Please specify)

**PART OF BODY INJURED**

Head (except eyes) Eyes Face

Neck, back, spine Chest, abdomen Shoulder

Upper arm Elbow Lower arm

Wrist Hand Finger (one or more)

Hip joint, thigh, kneecap Knee joint Lower leg

Ankle Foot Toe (one or more)

Multiple injuries

Trauma, shock

Other (Please specify)

**MAIN AGENT WHICH CAUSED ACCIDENT / DESCRIPTION:**

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

**REPORTING MANAGER**

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WITNESS DETAILS**

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_