



## ACCIDENT INVESTIGATION FORM

| <b>1 Particulars of Injured Person</b>   |  |                     |  |
|--|--|---------------------|--|
| Give full name   |  | Give the occupation |  |
| Give the home address  |  |                     |  |
| Name   |  | Occupation          |  |
| Address  |  |                     |  |
| Postcode   |  |                     |  |
| Next of Kin  |  | Relationship        |  |
| Give the home address  |  |                     |  |
| Name   |  | Relationship        |  |
| Address  |  |                     |  |
| Postcode   |  |                     |  |
| Normal Hours of Work:                      From <input style="width: 100px;" type="text"/> To <input style="width: 100px;" type="text"/> |  |                     |  |
| Actual Hours Worked:                      From <input style="width: 100px;" type="text"/> To <input style="width: 100px;" type="text"/>  |  |                     |  |

| <b>2 Accident Information</b>                          |  |                              |                             |
|--|--|------------------------------|-----------------------------|
| When it happened                                       |  | Time of accident             |                             |
| Date   |  | Time                         |                             |
| When it was reported                                   |  | Time                         |                             |
| In what room or place did the accident occur?          |  |                              |                             |
|  |  |                              |                             |
| Was the injured person authorised to be in that place? |  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If No, give details below:                             |  |                              |                             |
|  |  |                              |                             |
| Details of the Accident:                               |  |                              |                             |
|  |  |                              |                             |
| Was the person properly trained to carry out the work? |  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If No, why was that person carrying out the work?      |  |                              |                             |
|  |  |                              |                             |
| Do Safe Operating Procedures exist for the task?       |  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Was the injured person aware of these?                 |  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Was the injured person adhering to them?               |  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If No, why not?  |  |                              |                             |
|  |  |                              |                             |



|  |   |   |
|--|---|---|
| Were there any witnesses?                            | Yes <input type="checkbox"/>                    | No <input type="checkbox"/>                   |
| If so, give Names and Positions within the Company   |   |   |
|  |   |   |
| Was the injured person able to continue normal work? | Yes <input type="checkbox"/>                    | No <input type="checkbox"/>                   |
| Would protective clothing/equipment prevent injury?  | Yes <input type="checkbox"/>                    | No <input type="checkbox"/>                   |
| If Yes but not worn, state why                       |   |   |
|  |   |   |
| What were the causes of the accident?                | Tick all of the applicable boxes:               |   |
| Serious Emergency <input type="checkbox"/>           | Insufficient Space <input type="checkbox"/>     | Cold <input type="checkbox"/>                 |
| Condition of Tools <input type="checkbox"/>          | Obstruction <input type="checkbox"/>            | Fumes <input type="checkbox"/>                |
| Defective Footwear <input type="checkbox"/>          | Incorrect Lifting <input type="checkbox"/>      | Steam <input type="checkbox"/>                |
| Faulty Equipment <input type="checkbox"/>            | Slippery Floors <input type="checkbox"/>        | Poor Light <input type="checkbox"/>           |
| Method of Working <input type="checkbox"/>           | Excessive Heat <input type="checkbox"/>         | Rushing <input type="checkbox"/>              |
| Lack of Supervision <input type="checkbox"/>         | Over Reaching <input type="checkbox"/>          | Horseplay <input type="checkbox"/>            |
| Instructions Ignored <input type="checkbox"/>        | Wrong Tools <input type="checkbox"/>            | Untidiness <input type="checkbox"/>           |
|  | Tools Used Incorrectly <input type="checkbox"/> | Excessive Force Used <input type="checkbox"/> |
|  | Lack of Training <input type="checkbox"/>       | Procedures Ignored <input type="checkbox"/>   |
|  | Violence <input type="checkbox"/>               |   |
| Any other cause? (specify)                           |   |   |
|  |   |   |

|  |                          |                    |                          |
|--|--------------------------|--------------------|--------------------------|
| <b>3 Treatment Details</b>                     |                          |                    |                          |
| Type of Injury                                 |                          |                    |                          |
|  |                          |                    |                          |
| Part of Body Injured?                          |                          | Treatment Given By |                          |
| Outline Treatment Given                        |                          |                    |                          |
|  |                          |                    |                          |
| Injured Person was sent: (tick as appropriate) |                          |                    |                          |
| back to work                                   | <input type="checkbox"/> | home               | <input type="checkbox"/> |
|  |                          | to hospital        | <input type="checkbox"/> |
| Details entered in Accident Book by            |                          |                    |                          |
|  |                          |                    |                          |

|                                      |      |
|--------------------------------------|------|
| <b>4 Statement of Injured Person</b> |      |
|                                      |      |
| Signature                            | Date |
|                                      |      |



**5 Statement of Witness**

|           |  |            |  |
|-----------|--|------------|--|
| Name      |  | Occupation |  |
|           |  |            |  |
| Signature |  | Date       |  |
| Name      |  | Occupation |  |
|           |  |            |  |
| Signature |  | Date       |  |

**6 Supervisor's Action Report**

|   |  |      |  |
|---|--|------|--|
| What action have you taken or do you recommend to prevent a recurrence of this accident/incident? |  |      |  |
|   |  |      |  |
| Signature   |  | Date |  |

**7 Review of Recommended Action**

|  |  |      |  |
|--|--|------|--|
| (To be completed by the appropriate Manager)   |  |      |  |
|  |  |      |  |
| I confirm that the measures proposed in Section 6 above have been completed (if no action has been taken, please explain why). |  |      |  |
|  |  |      |  |
| Signature  |  | Date |  |