Accident / Incident Report Form

This form should be completed by the injured worker or witness as soon after the accident or incident as practical.

Please complete all sections carefully.

1. Brief description of the accident / incident

2. As a result of this accident / incident was there injury suffered?

☐ **Yes** ☐ **No**

3. As a result of the accident / incident was there damage to property?

☐ **Yes** ☐ **No**

4. Describe damage to property (if applicable).

5. **Details of person with injury / illness (if applicable):**

Name: _____

Address: _____

_____

Phone: _____

☐ **Employee** ☐ **Visitor**

6. **Description of injury (ies) sustained.**

_____

_____

_____

_____

_____

_____

7. **First Aid given:**

☐ **Yes** ☐ **No**

Name of person administering First Aid: _____

Details: _____

_____

_____

8. **Ambulance called:**

☐ **Yes** ☐ **No**

9. After the incident:

- ☐ Person taken to hospital
- ☐ Person sent home
- ☐ Next of kin contacted
- ☐ Returned to work

11. Location where incident occurred:

- ☐ Office
- ☐ Warehouse
- ☐ Distribution
- ☐ Transit (to/from work)
- ☐ Other (Please specify) _____

12. Is the form being complete by:

- ☐ Injured worker
- ☐ Witness

Contact Details: _____

_____

_____

_____

Signature: _____ **Date:** _____