Accident and Incident Report Form

PERSONAL INFORMATION

Surname: _____ Given Name: _____ Date of Birth: _____

Classification: ☐ Director ☐ Volunteer ☐ Visitor ☐ Contractor

☐ Other: _____

Gender: ☐ Please identify: _____

Address:_____

_____

Contact Number: _____ Email: _____

ACCIDENT / INCIDENT DETAILS

Date of Accident/Incident: _____ Time: _____

Accident/Incident Location: _____

Description of Accident/Incident (supply photos and additional information if available):

_____

_____

_____

Property Damage Details (if applicable and estimated cost):

_____

_____

Names of the Person Involved and any Witnesses (please include contact details if follow up required):

_____

_____

Additional Information:

_____

_____

REQUIRED TREATMENT FOR PHYSICAL INJURY

☐ None ☐ First Aid Treatment: _____

Name of First Aid Officer: _____

☐ Sent Home Date: _____ Time: _____

☐ Attended Doctor (attach medical reports) Date: _____

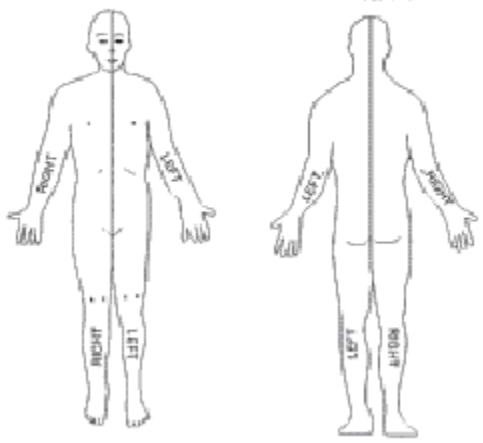
☐ Attended Hospital (attach medical reports) Date: _____

INJURY DETAILS

Please select the nature of the injury, indicate the body part, and cause of the injury:

☐ Amputation
☐ Asphyxiation
☐ Bruise or crushing
☐ Burn or scald
☐ Cut or open wound
☐ Dislocation
☐ Exposure
☐ Foreign body
☐ Headache or possible concussion
☐ Inhalation or respiratory
☐ Internal injury
☐ Possible fracture
☐ Possible poisoning
☐ Possible skin disorder
☐ Puncture
☐ Sprain or strain
☐ Other: _____

Body part
(please mark the injured part(s))



Please indicate what appears to be the cause of the injury

☐ Animal or insect
☐ Biological
☐ Chemical
☐ Electricity
☐ Equipment or tool (powered)
☐ Equipment or tool (non-powered)
☐ Explosion or implosion (pressure)
☐ Muscular effort
☐ Needle or sharp
☐ Radiation
☐ Slip trip or fall
☐ Stepping on or striking object
☐ Struck by moving object
☐ Thermal (heat or cold)
☐ Vehicle
☐ Vibration
☐ Other: _____

Is this an aggravation of a previous injury? ☐ Yes ☐ No

ADDITIONAL INFORMATION

_____

_____

REPORTING

Have you notified the CEO? ☐ Yes ☐ No Date Notified:_____

Has an insurance claim form been requested from the CEO? ☐ Yes ☐ No

SIGNATURES

Signature of Individual: _____ Date: _____

Signature of First Aid Officer: _____Date: _____

Witness: _____ Date: _____

INVESTIGATION

Is further investigation required? ☐ Yes ☐ No

What action has been taken to prevent the incident/accident occurring again?

_____

_____

_____

COPIES OF REPORT

This form should be completed within 48 hours of the occurrence, when possible, and submitted to the CEO. Where the CEO is reporting accidents or incidents on behalf of themselves, it should be reported to NRWC Executive.

Please keep a copy for your records.