

ACCIDENT INVESTIGATION FORM

Doc No. A01

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Name of organisation: Branch/department:

PARTICULARS OF ACCIDENT

Date of accident	Time	Location	Date reported
MTWTFSS			

THE INJURED PERSON

Name		Address		
Age	Phone number			
Date of accident		Length of employment		
TYPE OF INJURY:	<input type="checkbox"/> Bruising	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Other (specify)	Injured part of body
<input type="checkbox"/> Strain/sprain	<input type="checkbox"/> Scratch/abrasion	<input type="checkbox"/> Internal		
<input type="checkbox"/> Fracture	<input type="checkbox"/> Amputation	<input type="checkbox"/> Foreign body	Remarks	
<input type="checkbox"/> Laceration/cut	<input type="checkbox"/> Burn scald	<input type="checkbox"/> Chemical reaction		

DAMAGED PROPERTY

Property/ material damaged	Nature of damage
	Object/substance inflicting damage

THE ACCIDENT

Description

Describe what happened (space overleaf for diagram — essential for all vehicle accidents)

Analysis

What were the causes of the accident?

HOW BAD COULD IT HAVE BEEN?

☐ Very serious ☐ Serious ☐ Minor

WHAT IS THE CHANCE OF IT HAPPENING AGAIN?

☐ Minor ☐ Occasional ☐ Rare

Prevention

What action has or will be taken to prevent a recurrence? Tick items already actioned

Use space overleaf if required

TREATMENT AND INVESTIGATION OF ACCIDENT

Type of treatment given	Name of person giving first aid	Doctor/Hospital		
Accident investigated by	Date	OSH advised YES / NO	Date	