fascel mechanical

ACCIDENT/INCIDENT REPORT

A12

No:

Clearly print all information on this Report

INJURED PERSON (IP) DETAILS *(A separate form is to be completed for each IP)*								
Was the IP -	an Employee?		Employee No:					
on a training scheme?		self-employed and at work?		on work experience?				
member of the public?		employed by someone else? Contractor/Other* Company Name *(if applicable)*:						
Job Title/Region/Dept:		Details if the IP was on a training scheme/employed by someone else:						
Surname:		Forename/s:						
Home Address (incl postcode):								
Male / Female *(delete)*	Tel No/s:			DoB:				
INCIDENT DETAILS								
When did the incident occur?		Date:		Time:				
Was this during the agreed hours?	YES/NO*							
Where did the incident occur *(exact location if possible)*?								
Details of any first aid treatment given (and name of First Aider if known):								
Nature of any injuries and part/s of body affected (state left or right):								
What was the severity of any injury? *(tick ONE box)*	Injury preventing the IP from working for more than 7 days		Major injury		Fatality			
Excl. day of accident will IP be off work more than 7 days *(including the weekend)*?	YES/NO/NOT KNOWN*	Estimated no of days absence:						
Did the IP attend hospital?	YES/NO*							
Did the injured person *(tick all boxes that apply)*:	Become unconscious		Need resuscitation					
Remain in hospital for more than 24 hours		If hospitalised, number of days in Hospital:						
Give brief description of events leading up to accident/incident and how accident/incident occurred *(include measurements [eg fall from height in metres] and photographs where applicable/available)*: *(If necessary, continue overleaf/on separate sheet)*								
Is CCTV footage available?	YES/NO*							
Incident area condition details *(eg wet/icy/dry/crowded etc include photographs, where available)*:								
Property/Equipment/Machinery damage details *(include photographs/ sketches, where possible)*:								
Who attended? *(tick all boxes that apply)*	First Aider		Fire Service		Ambulance		Police	

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Appointed Person		HSE Officer		EHO		EA		Other	

* *Delete as applicable*

No:

Name/s, address/es and telephone numbers of any witnesses:			Statement/s taken - YES/NO* (If YES, statement/s attached): YES/NO*
ACTION TAKEN TO PREVENT RECURRENCE & FURTHER ACTION INTENDED TO BE TAKEN?			
Root cause:			
Contributing factors:			
Name of person completing report *(If not IP)*:			Job Title:
Home Address:			
Postcode:	Signature:		Date:
Reported to Enforcement Authority?	YES/NO/n/a*	Date:	Report Number:
Method or reporting: online/telephone *(telephone only for major injury/fatality)*			
I declare the information given on this form is true to my recollection -			
Signature of IP *(to confirm that it is correctly completed)*:			Date:
Name:			Time:

* *Delete as applicable*

A plan of the accident may be drawn below and any additional injured person/s and witness statements attached. Please ensure that the Accident/Incident Reference No (inserted at the top of this form) is included on any attachments.