

Accident Investigation

NAME OF ORGANISATION BRANCH/ DEPARTMENT

PARTICULARS OF ACCIDENT			
Date of accident			

THE INJURED PERSON				
Name		Address		
Age	Phone number			
Date of accident		Length of employment — at plant		on job
	<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? <input type="checkbox"/> Very serious <input type="checkbox"/> Serious <input type="checkbox"/> Minor		WHAT IS THE CHANCE OF IT HAPPENING AGAIN? <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional <input type="checkbox"/> Rare		
PREVENTION	What action has or will be taken to prevent a recurrence? Use space overleaf if required	Tick items already actioned	By whom	When

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