

# Accident Investigation

Name of organisation: ..... Branch/department: .....

## PARTICULARS OF ACCIDENT

|                                       |      |          |               |
|---------------------------------------|------|----------|---------------|
| Date of accident<br><br>M T W T F S S | Time | Location | Date reported |
|---------------------------------------|------|----------|---------------|

## THE INJURED PERSON

|   |   |  |  |                      |
|---|---|--|--|----------------------|
| Name                                    |   | Address                                    |  |                      |
| Age                                     | Phone number                              |  |  |                      |
| Date of accident                        |   | Length of employment — at plant            | on job                                   |                      |
| <b>TYPE OF INJURY:</b>                  | <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)

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### Analysis

What were the causes of the accident?

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HOW BAD COULD IT HAVE BEEN?

Very serious    Serious    Minor

WHAT IS THE CHANCE OF IT HAPPENING AGAIN?

Minor    Occasional    Often

### Prevention

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

| Use space overleaf if required | By whom | When |
|--------------------------------|---------|------|
|                                |         |      |
|                                |         |      |
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|                                |         |      |
|                                |         |      |

## TREATMENT AND INVESTIGATION OF ACCIDENT

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