|  |  |
| --- | --- |
| Date of Accident/Incident:  | Time of Accident/Incident:  |
| Location: |
| Reported by: Company:  | Date Reported: Reported to:  |

**Details of Person(s) involved:**

|  |  |
| --- | --- |
| Name:  | ID Number:  |
| [ ]  Staff [ ]  Student [ ]  Other (Please Specify): |

**Details of any injuries:**

|  |
| --- |
| **Type of Injury: No Injuries**: [ ]  Graze/Scratches: [ ]  Cut/Laceration: [ ]  Dislocation: [ ]  Fracture: [ ] Chemical Splash: [ ]  Concussion: [ ]  Puncture: [ ]  Scald: [ ]  Electric Shock: [ ]  Sprain: [ ]  Bruise: [ ]  Burn: [ ] Bite: [ ]  Other(Please Specify): [ ]   |
| **Body Part affected:**Head: [ ]  Face: [ ]  Eyes: [ ]  Neck: [ ]  Shoulder (L/R): [ ]  Chest: [ ]  Abdomen: [ ]  Arm (L/R):[ ]  Hand (L/R):[ ]  Leg (L/R): [ ]  Right Hand Back: [ ]  Ankle (L/R): [ ]  Foot (L/R): [ ] Other (Please Specify): [ ]  Hip broken  |
| **Treatment: No treatment necessary**:[ ] First Aid: [ ]  Name of FAR:Doctor**:** [ ]  Hospital**:** [ ]  Other (Please Specify): [ ]  |

|  |
| --- |
|  |

**Details of what happened:** (provide as much detail as possible, use additional sheets if necessary)

|  |
| --- |
|  |

**Actions required to prevent a recurrence:**

|  |  |  |
| --- | --- | --- |
| **Action** | **Responsible** | **Due By** |
| **None.** |  |  |

Signature(Person completing this Report): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

**Please forward completed report to the Health & Safety Manager**