**[NAME OF COMPANY]**

**ACCIDENT**

**REPORT FORM**



All accidents are considered by companies as incidents. However, an accident report focuses on the injury, while an incident report focuses on the causes and prevention of repeat occurrences of incidents.

Accident reports have two parts, the first part of which is completed by the employee who suffered from the accident, while the second part is completed by the supervisor.

An accident report is an important tool that is used to document the accident and assist in the investigation regarding the cause. It also assists to develop procedures that companies may put in place to prevent such accidents from happening again.

A manager or supervisor of the injured employee’s department should decide whether or not the accident should be documented as an incident needing further investigation.

**REPORT COMPLETED BY:**

**DATE REPORTED:**

|  |  |  |
| --- | --- | --- |
| **Last Name of Injured Person** | **First Name** | **Job Title and Position** |
| **Date of Accident** | **Time** | **Location** |
| **Date Ceased Work** | **Time Lost to Date** | **Anticipated Time Loss Overall** |
| **Name of Supervisor** | **Job Title** | **Name of Witnesses** |
| **Full Description of Injuries** | | |
| **Employee’s Account of the Accident**  [Include sequence of events] | | |
| **Basic Cause and Contributory Causes**  [Explain unsafe actions, conditions, personal factors, and etc.] | | |
| **Recommended Corrective Measures** | | **Action Taken By** |
| **Names of the Inspection Team Members** | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Nature and Extent of the Injury** | | | |
| **Part of Body Injured** | ☐ Head  ☐ Eyes  ☐ Neck | ☐ Trunk  ☐ Arm  ☐ Leg | ☐ Multiple  ☐ General  ☐ Unspecified |
| **Nature of Injury** | ☐ Sprain  ☐ Fracture  ☐ Multiple  ☐ Contusion | ☐ Laceration  ☐ Concussion  ☐ Dislocation  ☐ Other | ☐ Burn  ☐ Superficial  ☐ Amputation |
| **Type of Incident** | ☐ Flying Object  ☐ Struck By  ☐ Caught In | ☐ Manual Handling  ☐ Poison  ☐ Temperature | ☐ Electricity  ☐ Fall  ☐ Other |
| **Cause of Accident** | ☐ Ineffective Guard  ☐ Lack of Maintenance  ☐ Unsafe Methods  ☐ Weather | ☐ Lack of Equipment  ☐ Not Following Safety Rules  ☐ Misconduct  ☐ Poor Housekeeping | ☐ Lack of Training  ☐ Inexperience  ☐ Workplace Design  ☐ Language Difficulty |
| **Supervisor’s Comments** | | | |

|  |  |
| --- | --- |
| **Government/Insurance Bodies Advised** | **Date Advised** |
| **Management Review By** | **Date to Be Completed** |
| **Signature** | **Date** |