

## 1. Particulars of Accident

Date of accident: DD / MM / YEAR

Time:

Location:

Date reported: DD / MM / YEAR

## 2. The Injured Person

Name:

Address:

Date of birth: DD / MM / YEAR

Phone number:

### Type of Injury

- Bruising    Dislocation    Strain/sprain  
 Scratch/abrasion    Internal    Fracture  
 Amputation    Foreign body    Laceration/cut  
 Burn/scald    Chemical reaction  
 Other: (specify injured part of body)

Comments:

## 3. Damaged Property

Property or material damaged:

Nature of damage:

Object/substance causing damage:

## 4. The Accident

Description:

Describe what happened.  
If this was a vehicle accident, add a drawing of the accident scene on the other side of this page.

Analysis:

What caused the accident?

How serious could it have been?

- Minor    Serious    Very serious

How often is this likely to happen again?

- Never    Rarely    Occasionally    Often

Prevention:

What action has or will be taken to stop another accident like this happening?

Tick items already actioned.

Write below if you need more space.

ACTION	TICK	BY WHOM	WHEN
	<input type="checkbox"/>		
	<input type="checkbox"/>		
	<input type="checkbox"/>		
	<input type="checkbox"/>		
	<input type="checkbox"/>		

**5. Treatment and Investigation of Accident**

Type of treatment given:

Name of person giving first aid:

Doctor/Hospital:

Accident investigated by:

Date: DD / MM / YEAR

WorkSafe advised:    Yes    No

Date: DD / MM / YEAR