

Annex: – Accident Report Form

Accident Investigation Report Form:

EMPLOYEE DETAILS

Name: _____

Sex: _____ Designation: _____

Address: _____

INDIVIDUAL DETAILS (other than employee)

Name: _____

Sex: _____

Address: _____

INJURY DETAILS

Date of accident: _____ Time: _____ Date Reported: _____ Time: _____

Date ceased work: _____ Time: _____ Supervisor: _____

Time lost (to date): _____ Time lost (anticipated overall) _____

Medical Treatment required: _____

Accident Investigation - Supervisor's Report

Witness Details			
How did the accident happen			
What caused the accidents	<input type="checkbox"/> Ineffective guarding	<input type="checkbox"/> Lack of protective equipment	<input type="checkbox"/> Lack of training
	<input type="checkbox"/> Lack of maintenance	<input type="checkbox"/> Safety rules not followed	<input type="checkbox"/> inexperience
	<input type="checkbox"/> Unsafe work methods	<input type="checkbox"/> Misconduct	<input type="checkbox"/> Workplace design (equipment, design, layout)
	<input type="checkbox"/> Weather	<input type="checkbox"/> Poor housekeeping	<input type="checkbox"/> Language difficulties
Explain			
How can a recurrence be prevented?			

Supervisor's name: _____

Signature: _____ Date: _____

Appropriate Government/insurance bodies Advised? (If applicable) Yes/No

Date : _____

Is this a Work-related injury? Yes/No

