

# INCIDENT OR NEAR MISS REPORT FORM

## Personal details

Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Section/Dept: \_\_\_\_\_ Date of report: / /

## Accident/incident details

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Date reported: / /

Location: \_\_\_\_\_ Witness: \_\_\_\_\_

Reported to whom: \_\_\_\_\_

**Full accident/incident details** – what happened, or in the case of a near miss, what could have happened

## Injury – Nature of Injury

- |  |   |                                       |  |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> Contusion/crush       | <input type="checkbox"/> Burn               | <input type="checkbox"/> Dislocation  | <input type="checkbox"/> Amputation      |
| <input type="checkbox"/> Laceration/open wound | <input type="checkbox"/> Superficial injury | <input type="checkbox"/> Foreign body | <input type="checkbox"/> Internal injury |
| <input type="checkbox"/> Concussion            | <input type="checkbox"/> Sprain/strain      | <input type="checkbox"/> Fracture     | <input type="checkbox"/> Dermatitis      |

## Location of Injury

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Head/face     | <input type="checkbox"/> Eye           | <input type="checkbox"/> Internal organs         |
| <input type="checkbox"/> Hand/fingers  | <input type="checkbox"/> Shoulder/arms | <input type="checkbox"/> Trunk (other than back) |
| <input type="checkbox"/> Hip/leg       | <input type="checkbox"/> Foot/toes     | <input type="checkbox"/> Back                    |
| <input type="checkbox"/> Other (state) |  |  |

## Results of accident

Lost time injury Y / N      No. of days: \_\_\_\_\_ days      Workers' compensation Y / N

Treatment received:       First aid       Doctor       Hospital

## Damage to equipment/buildings/vehicles etc.

What was damaged? \_\_\_\_\_

Extent of damage: \_\_\_\_\_

## Contributing factors

What were the contributing factors (if any)? \_\_\_\_\_

## Corrective actions

Immediate actions \_\_\_\_\_

What controls can be put in place to prevent this from happening again? \_\_\_\_\_

Recommendations for action \_\_\_\_\_

Who is to implement these controls/corrective actions? \_\_\_\_\_

Date by which action is to be taken / /

## Signatures (Where Relevant)

Effected Persons: \_\_\_\_\_ HS Rep: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Witness: \_\_\_\_\_ Investigating officer: \_\_\_\_\_

Actions completed: \_\_\_\_\_ Date: / / Supervisor: \_\_\_\_\_