Example Accident Report Form

People Dancing
the foundation for community dance

About you

1. What is your full name?
2. What is your job title?
3. What is your telephone number?
4. What is the name of your organisation?
5. What is its address? postcode
6. What type of work does the organisation do?

About the injured person

If more than one person was injured in the same incident, fill out the following information in relation to each person.

1. What is their full name?
2. What is their address? postcode
3. What is their home phone number?
4. How old are they?
5. Are they male or female? male female
6. What is their job title?
7. Was the injured person (tick only one)

one of your employees? on work experience?
on a training scheme? employed by someone else?

About the incident

1. On what date did the incident happen?
2. At what time did the incident happen?
3. Did the incident happen at the above address? yes no

If not, where did the incident happen (giving address and post code)?

About the injury

1. What was the injury? (eg fracture, laceration)

2. What happened?

Describing what happened. Give as much details as you can. For instance, the name of any substances involved an injury to an employee or self-employed - the name and type of any machine involved person which prevented them doing their - the events that led to the incident normal work for more than 3 days? Did the person remain in hospital for more than 24 hours?

3. What part of the body was injured?

4. Was the incident

- ◯ fatality?
- ◯ a major injury or condition?
- ◯ an injury to a member of the public which meant they had to be taken from the scene for treatment?
- ◯ an injury to an employee or self-employed - the name and type of any machine involved person which prevented them doing their - the events that led to the incident normal work for more than 3 days?

5. Was the injured person (tick all that apply)

- ◯ In contact with moving machinery or material being machined
- ◯ Hit by a moving, flying or falling object
- ◯ Hit by a moving vehicle
- ◯ Hit something fixed or stationary
- ◯ Injured while handling, lifting or carrying
- ◯ Slipped, tripped or fell on the same level
- ◯ Trapped by something collapsing
- ◯ Drowned or asphyxiated
- ◯ Exposed to, or in contact with, a harmful substance
- ◯ Exposed to an explosion
- ◯ Contact with electricity or an electrical discharge
- ◯ Injured by an animal
- ◯ Physically assaulted by a person
- ◯ Fell from a height How high was the fall?
- ◯ Another kind of accident

Witnesses

1. Where there any witnesses to the incident? ◯ yes ◯ no
   If there were witnesses, record their name and contact details

Your Signature

Date
(that this form is completed and signed)