ACCIDENT REPORT & INVESTIGATION

FORM

IN LIEU OF BI 510

PART 1

1. Project reference number.	
2. Date and time of the incident.	
3. Date and time reported.	
4. Name and address of the company and person making the report.	
5. Location of the place of the accident (site address).	
6. Name & address of who was injured/ suffered ill health or otherwise involved in the accident.	
7. Male / Female.	
8. Name and address and phone number of Contractor (if applicable).	
9. If not, name the Director informed.	
10. What injuries or ill health effects were caused?	
11. Treatment/advice provided?	
12. Can work still be carried out safely?	
13. Has the injured person returned to work immediately?	
14. Are there any witnesses, if so please provide details?	

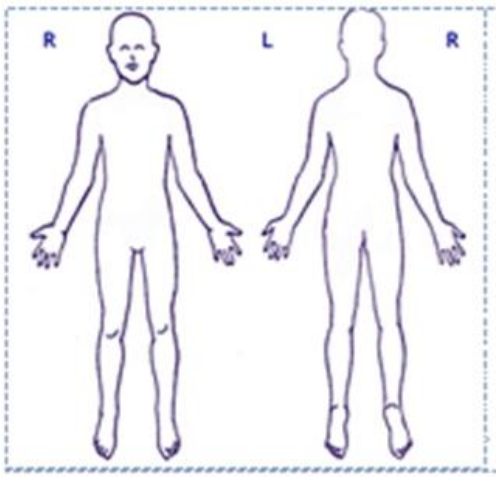
IN LIEU OF BI 510

PART 2

Nature of injury **Category of injury** **Location of injury (mark in red ink)**

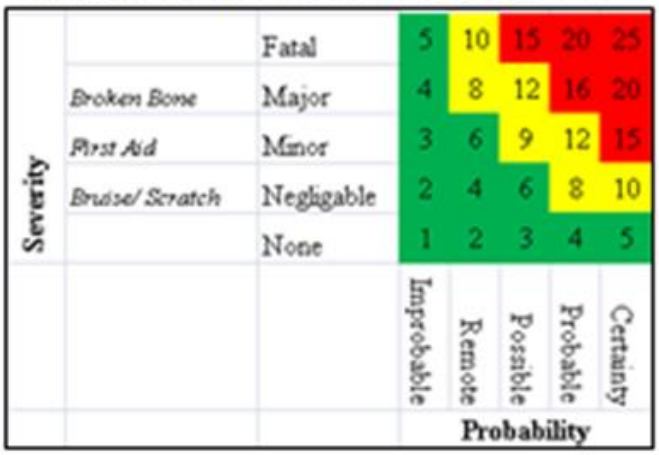
Wound	
Bruise	
Sprain/strain	
Burn	
Abrasion	
Foreign body	
Dislocation	
Unconscious	
Fracture	
Electrocution	
Poisoning	
No recognisable injury	
Graze	
Other (please state)	

Slip, trip, fall	
Manual Handling	
Fall from height	
Burn (heat)	
Burn (chemical	
Hit by object	
Struck by object	
Use of tools	
Use of vehicles	
Exposure to substance	
Crush injury	
Assault	
Needle stick	
Other (please state)	



Confirm the precise location of the injury on the body (i.e. the tip of the left index finger or the bottom of the right-hand palm)	

What is the worst possible outcome of this accident?



Probability X Severity =	
How likely is it that this accident could occur again? (use probability 1-5) =	

IN LIEU OF BI 510

PART 3

1. How did the accident happen (Note working environment issues, layout, equipment and or substances involved – did these influence the accident)	
2. Was there anything unusual or different about the working environment?	
3. Was the maintenance and housekeeping sufficient, if not explain why?	
4. Were there adequate safe procedures and were they being followed?	
5. Was the injured person trained and competent to carry out the activities?	
6. Has the injured person returned to work?	
7. Off work for over 3 days?	
8. Over is the accident likely to be an over 7-day injury?	
9. Did the injured person go to hospital?	
10. What further action needs to be implemented to prevent recurrence?	

Name:	Signature:	Date:

WHEN COMPLETED THIS FORM MUST NOT BE HELD ON SITE
SEND TO HEAD OFFICE FOR THE ATTENTION OF THE HEALTH AND SAFETY DEPARTMENT

STATEMENT FORM

PART 4

This statement is made in relation to the incident that occurred on: (Date) …….

Involving (Name of injured part or title of incident) …….

I the undersigned was working at……..

On the day of the incident was working in/on and observed:

Person making statement

Signed…… Print Name……

Person witnessing statement

Signed…… Print Name……

Date statement taken ……

CONTINUATION SHEET

This statement is made in relation to the incident that occurred on Date: …….

Involving (Name of injured part or title of incident) …….

Person making statement

Signed…… Print Name……

Person witnessing statement

Signed…… Print Name……

Date statement taken. ……