

VILLAGE OF HESPERIA

ACCIDENTS/INCIDENTS/DANGEROUS OCCURENCES

ACCIDENT / INCIDENT REPORT FORM

1. DEPARTMENT: _____ Ref No.: _____ _____
2. CENTRE / ESTABLISHMENT: _____
3. INJURED PERSON: First name: _____ Last Name: _____ Address: _____ Date of Birth: _____ Sex: _____ Telephone No: _____ a) Employee? Occupation: _____ Payroll No: _____ Did he/she do any work after the incident/accident? Yes / No If no, when did they finish work? Time: _____ Date: _____ Was work engaged in at time of accident Yes / No Normal hours of work on day of incident/accident: From: _____ To: _____ / incident a recognised part of his/her duties? b) Employee?: Non-Employee
4. PLACE WHERE THE ACCIDENT / INCIDENT HAPPENED: <i>(including name and address):</i>
5. DATE AND TIME OF ACCIDENT / INCIDENT:
6. DESCRIPTION OF ACCIDENT / INCIDENT: <i>(Continue on separate sheet if needed):</i> Additional Information: <i>(e.g. circumstances leading up to the accident /incident, etc.):</i>
7. INJURY DETAILS: Part of Body <i>(indicate L or R where necessary):</i> _____ Nature of Injury <i>(eg fracture, sprain, cut, etc):</i> _____ Treatment given: _____ First aid treatment given by: _____ Was the injured person taken to hospital from the scene of the accident/incident? Yes / No If yes, which hospital? _____ Were they detained? Yes / No If yes, how long? _____ <i>The next questions relate to Employees only...</i> Has the injured person been referred to Occupational Health? Yes / No Has the injured person visited their own Doctor as a result of the accident / incident? Yes / No Has the injured person been unable to do their work for 3 or more days as a result of the accident/incident? Yes / No

8. WITNESSES TO ACCIDENT

1. Name: _____
Address: _____
Tel No: _____

2. Name: _____
Address: _____
Tel No: _____

9. **TO WHOM WAS ACCIDENT REPORTED:** Yes / No

If yes, by whom _____ Date: _____

9a. **PERSON MAKING REPORT:** Name: _____ Designated Post/Occupation: _____

Signature: _____ Date: _____ Address: _____

-*THIS PAGE IS CONFIDENTIAL TO THE DEPARTMENT

THIS SECTION FOR USE BY SUPERVISOR

10. Accident / incident cause and/or contributory factors:

Action to Prevent Recurrence: _____

Does risk assessment require revision? Yes / No If yes, describe: _____

Name: _____ Date: _____

Designated Post: _____ Signature: _____