

Accident / Incident – Injury

For use with www.assessnet.co.uk

About the Incident

| | |
|--|--------------------------|
| Accident Centre | |
| When the Incident occurred | / / : (DD/MM/YYYY HH:MM) |
| What department is associated with the incident? | |
| Where did the incident happen? (i.e. customer car park) | |

About the person who was injured

| | |
|-------------|---------------|
| Name | |
| Street | |
| Town / City | |
| County | |
| Postcode | |
| Occupation | |
| Status | |
| Gender | Male / Female |
| Age (Years) | |

About the person filling in this form

| | |
|-------------|--|
| Name | |
| Street | |
| Town / City | |
| County | |
| Postcode | |
| Occupation | |

About the Injury

Enter as much detail as possible

| | |
|---|--|
| Injury Type | |
| Apparent Cause | |
| Part of body affected | |
| Where did the injury happen? Specify the room or place where the accident occurred | |

| | |
|--|--|
| How did the injury happen? What injuries were sustained? Give the cause if you can. In the event of any personal injury, please specify. | |
| What materials were used during treatment / first aid? E.g. bandages, plasters etc. | |
| Follow up actions Describe what has been done to prevent a recurrence | |

Lost Time Analysis

| | |
|---|-----------------|
| Please state the number of days this person has been away from work or unable to do their normal job | Days |
| Includes day of incident (Mark Yes if the value above includes the day on which the incident took place) | Yes / No |

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995

Section A (If the injury occurred to an Employee / Trainee / Self employed person complete this Section)

| | |
|--|-----------------|
| Did this injury result in a fatality | Yes / No |
| Did this injury result in a major injury (e.g. Fracture other than fingers or toes, Amputation, Loss of sight, Acute illness etc) | Yes / No |
| Did the accident cause the person to be away from work or unable to do their normal job for MORE THAN 7 days? (refer to number of days entered above) | Yes / No |
| Did the employee / trainee / self employed person remain in hospital for 24 hours or more? | Yes / No |

Section B (If the injury occurred to a Member of the public / Volunteer / Service user complete this section)

| | |
|---|-----------------|
| Did this injury result in a fatality | Yes / No |
| Was the member of the public / volunteer taken to hospital by any means? | Yes / No |

Note: If any of the above were answered Yes, then please report to RIDDOR
 If this accident is RIDDOR reportable, please fill out these few sections

Was the injured person ... (Please tick one)

| | |
|--------------------------|---|
| <input type="checkbox"/> | One of your employees? |
| <input type="checkbox"/> | On a training scheme? Give details |
| | |
| <input type="checkbox"/> | On work experience? |
| <input type="checkbox"/> | Employed by someone else? Give details |
| | |
| <input type="checkbox"/> | Self-employed and at work? |
| <input type="checkbox"/> | A member of the public? (Includes volunteers and service users) |

Was the injury ... (Please tick one)

| | |
|--------------------------|--|
| <input type="checkbox"/> | A fatality? |
| <input type="checkbox"/> | a major injury or condition? |
| <input type="checkbox"/> | an injury to an employee or self-employed person which prevented them from doing their normal work for more than 3 days? |
| <input type="checkbox"/> | an injury to a member of public which meant they had to be taken from the scene of the accident to a hospital for treatment? |

Did the injured person ... (Please tick all that apply)

| | |
|--------------------------|--|
| <input type="checkbox"/> | Become unconscious? |
| <input type="checkbox"/> | Need resuscitation? |
| <input type="checkbox"/> | Remain in hospital for more than 24 hours? |
| <input type="checkbox"/> | None of the above? |