

# ACCIDENT / INCIDENT REPORT FORM



An accident form must be completed in the event of ALL accidents, incidents and "near-misses".

A departmental representative must countersign the form and forward the original copy IMMEDIATELY to SAFETY SERVICES, a copy to be retained by the department (Institute, School etc.)

Dept. form number

<b>Person Involved</b>	Title	First name	Second name
	<input type="text"/>	<input type="text"/>	<input type="text"/>
Home / Residence Address		Departmental Address	
<input type="text"/>		<input type="text"/>	
Phone No.	<input type="text"/>	Dept. phone No.	<input type="text"/>
Male <input type="checkbox"/>	Female <input type="checkbox"/>	Age <input type="text"/>	Job title <input type="text"/>
<b>Status:</b>	UCL staff <input type="checkbox"/>	UCL undergraduate student <input type="checkbox"/>	UCL graduate student <input type="checkbox"/>
			Contractor <input type="checkbox"/>
			Visitor <input type="checkbox"/>

**Where did the accident/incident happen? (building, floor, room)**

**When did accident happen?** Date  Time

**Details of the accident/incident**

*continue over page if necessary*

**Nature of any injuries involved:**

*continue over page if necessary*

**Did person lose consciousness?**  **Was person able to return to work immediately after treatment?**

<b>Indicate Treatment received</b>	None	First aid in Dept.	A&E at hospital	Own G.P.	Admitted to hospital
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Witness details:** Name and address   
(Departmental or home)  
Phone No.

**Name of Dept. supervisor or manager in attendance (if applicable)**

**Name and signature of Departmental Safety Officer**

<b>Safety Services use only</b>	Date received	Signature	Investigating ASO	SS Form No.
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Details of the accident/incident (continued):**

**Nature of any injuries involved (continued):**