

Report of an injury or dangerous occurrence

Filling in this form

This form must be filled in by an employer or other responsible person.

Part A

About you

1 What is your full name?

2 What is your job title?

3 What is your telephone number?

About your organisation

4 What is the name of your organisation?

5 What is its address and postcode?

6 What type of work does the organisation do?

Part B

About the incident

1 On what date did the incident happen?

2 At what time did the incident happen?
(Please use the 24-hour clock eg 0600)

3 Did the incident happen at the above address?

Yes Go to question 4

No Where did the incident happen?

elsewhere in your organisation-
give the name, address and postcode

at someone else's premises -give
the name, address and postcode

in a public place – give details of
where it happened

If you do not know the postcode, what is the
name of the local authority?

4 In which department, or where on the
premises, did the incident happen?

Part C

About the injured person

If you are reporting a dangerous occurrence, go
to Part F.

If more than one person was injured in the same
incident,

Please attach the details asked for in Part C and
Part D for each injured person.

1 What is their full name?

2 What is their address and postcode?

3 What is their home phone number?

4 How old are they?

5 Are they

male?

female?

6 What is their job title?

7 Was the injured person (tick only one box)

one of your employees?

on a training scheme? Give details:

on work experience?

employed by someone else? Give details
of the employer:

self-employed and at work?

a member of the public?

Part D

About the injury

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

2 What part of the body was injured?

3 Was the injury (tick the one box that applies)

- a fatality
- a major injury or condition? (see accompanying notes)
- an injury to an employee or self-employed person which prevented them doing their normal work for more than 3 days?
- an injury to a member of the public which meant they had to be taken from the scene of the accident to a hospital for treatment?

4 Did the injured person (tick all the boxes that apply)

- become unconscious?
- need resuscitation?
- remain in hospital for more than 24 hours?
- none of the above.

Part E

About the kind of accident

Please tick the one box that best describes what happened, then go to Part G.

- 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
- Fell from a height
- How high was the fall?
 metres
- Trapped by something collapsing
- Drowned or asphyxiated
- Exposed to, or in contact with, a harmful substance
- Exposed to fire
- Exposed to an explosion
- Contact with electricity or an electrical discharge
- Injured by an animal
- Physically assaulted by a person
- Another kind of accident (describe it in Part G)

Part F

Dangerous occurrences

Enter the number of the dangerous occurrence you are reporting. (The numbers are given in the Regulations and in the notes which accompany this form).

Part G

Describing what happened

Give as much details as you can. For instance

- the name of any substances involved
- the name and type of any machine involved
- the events that led to the incident
- the part played by any people

If it was personal injury, give details of what the person was doing. Describe any action that has since been taken to prevent similar incident. Use a separate piece of paper if you need to.

Part H

Your Signature

Signature

Date

Where to send the form

Please send it to the Enforcing Authority for the place where it happened. If you do not know the Enforcing Authority, send it to the Health and Safety Executive for Northern Ireland, 83 Ladas Drive, Belfast BT6 9FR

For official use

Client number	Local number	Event number	
<input style="width: 95%; height: 15px;" type="text"/>	<input style="width: 95%; height: 15px;" type="text"/>	<input style="width: 95%; height: 15px;" type="text"/>	<input type="checkbox"/> IVP REP <input type="checkbox"/> Y <input type="checkbox"/> N