FORM D
REPORT OF ACCIDENT / INCIDENT

1. Date and Time of Accident / Incident:

2. Name of Division/Unit:

3. Place of accident / incident with details as to the exact location:

4. Nature of Industry:

5. Injured person's name:
   Address:

6 a. Sex of injured person:

   b. Age of injured person:

   c. Designation of the injured person:

   d. CPF / ECP / ESI Number:

7. Monthly wages/pay of the person injured:

8. Circumstances under which accident/incident occurred:

9. Nature of injury (with part of the body affected):

10. Whether First-Aid was given and if so, by whom:

11. Has he/she been sent to the Doctor/Hospital and if so,
    the name of the Doctor/Hospital:

12. Measures taken to prevent such accident/incident:

I certify that to the best of my knowledge and belief that the above particulars are correct in every respect.

Name:
Designation:
Division/Unit : **Signature of officer in charge**

1. Copy to Occupational Health Centre
2. Copy to CISF / Main Gate.
3. Copy to Safety Division.
4. Copy to HR.