**HAZARD/INJURY/INCIDENT REPORT FORM**

|  |  |
| --- | --- |
| **CASE NUMBER:** |  |
| **DATE FILED:** |  |

*Section A. PERSONAL DETAILS*

|  |  |
| --- | --- |
| **Name:** |  |
| **Complete Address:** |  |
| **Telephone:** |  |
| **Department:** |  |
| **Position:** |  |

*Section B. INCIDENT DETAILS*

|  |  |
| --- | --- |
| **Date:** |  |
| **Time:** |  |
| **Location:** |  |
| **Witness:** |  |

*Section C. FULL BLOWN REPORT OF THE INCIDENT (Kindly state in paragraph form the details of the incident)*

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| --- |
|  |

*Section D. NATURE OF INJURY (Kindly check all that apply)*

Open Wound

Concussion

Burn

Dislocation

Amputation

Sprain

Strain

Fracture

Internal Injury

Trigger of existing condition (eg. High Blood Pressure)

Others (Please specify)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Section E. RESULT OF THE INCIDENT*

|  |  |
| --- | --- |
| **Lost time injury?** | Yes No |
| **Number of days:** |  |
| **Treatment Received:** | First Aid Hospital Home Care |

*Section F. EQUIPMENT DAMAGE*

|  |  |
| --- | --- |
| **What was damaged?** |  |
| **What were the contributing factors?** |  |
| **What was the extent of damage?** |  |
| **What are the controls that can be put in place to prevent this from happening again?** |  |

*Section G. RECOMMENDED ACTIONS*

|  |  |
| --- | --- |
| **List the recommended actions:** | **Action A:**  **Action B:**  **Action C:**  **Action D:**  **Action F:** |
| **Who will implement these actions?** |  |
| **Target date when the action should be taken?** | **Action A:**  **Action B:**  **Action C:**  **Action D:**  **Action F:** |

*Signatories:*

|  |  |
| --- | --- |
| **OSH Officer:** |  |
| **Human Resources Representative:** |  |
| **Manager:** |  |
| **Director:** |  |
| **Investigating Officer:** |  |