**EMPLOYEE’S REPORT OF INJURY / ILLNESS / NEAR MISS**

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| **I am reporting a work-related:** Injury  Ill-health  Near Miss |

**YOUR DETAILS**

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| **Name: Job Title:** |
| **Address:** |
| **Manager/Supervisor:** |
| **Have you told your Manager/Supervisor about this incident?** Yes  No |

**WHEN DID IT HAPPEN/START?**

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| --- | --- | --- |
| **Day:** | **Date:** | **Time:** |

**WHERE DID IT HAPPEN?** (This should be as precise as possible. For example: Which building? Which room? Which area? Outdoors? – where exactly?)

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| **It happened in…** |

**WHAT HAPPENED?** (Include what you were doing at the time and events that led up to it, including as much detail as you can. Try to describe it step-by-step. Include relevant details, such as light or weather conditions, if they may have affected what happened.)

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| Yes  No  If Yes, then give details: |

**Was it related to the work being done or the place the work was being done?**

**Was any equipment or substance involved?**

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| Yes  No  If Yes, then what? |

**Was anything damaged?**

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| Yes  No  If Yes, then what? |

**Did you take any photos of the incident or injuries?** Yes  No

**Were there any witnesses?** (Complete details for each witness)

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| --- | --- | --- |
| **Name** | **Job Title** | **Address** |
|  |  |  |
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**What do you think could have been done to prevent this incident?** (If anything)

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**About an INJURY or NEAR MISS** (What was the injury? Which parts of your body were injured? How serious was the injury? If it was a near-miss, how **could** you have been hurt?)

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| Fracture (other than to fingers, thumbs and toes) |  |
| Amputation |  |
| An injury likely to lead to permanent loss of sight or reduction in sight |  |
| A crush injury to the head or torso causing damage to the brain or internal organs |  |
| Serious burns (including scalding) which cover more than 10% of the body or caused significant damage to the eyes, respiratory system or other vital organs |  |
| Scalping requiring hospital treatment |  |
| Loss of consciousness caused by head injury or asphyxia |  |
| An injury arising from working in an enclosed space (which led to hypothermia or heat-induced illness or required resuscitation or admittance to hospital for more than 24 hours). |  |
| Another injury? (What was the injury?) |  |
| **Which part(s) of your body was/were injured?**  **How serious was the injury?**  **Any other comments about the injury?** | |

**Was any first aid given?**

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| Yes  No  If Yes, then what?  Who gave the first aid? |

**What happened next?**

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| --- | --- | --- | --- |
| **Back to work** | **Doctor** | **Hospital** | **Other** |
| Details about Hospital/Doctor/Other: | | | |

**How much time off was needed?** (Days)(not including the day of the injury)

**About ILL-HEALTH**

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| --- | --- |
| Carpal tunnel syndrome |  |
| Severe cramp of the hand or forearm |  |
| Occupational dermatitis |  |
| Hand-arm vibration syndrome |  |
| Occupational asthma |  |
| Tendonitis or tenosynovitis of the hand or forearm |  |
| An occupational cancer |  |
| A disease attributed to an occupational exposure to a biological agent |  |
| Another form of ill-health? (What type of ill-health?) |  |
| **Any other comments about the ill-health?** | |

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| **I consent to my personal information being shared:** Yes  No |

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| **Signature (if completed by hand):**  **Date form completed:** |

**Person completing this form**(Only complete this if you are completing the form on behalf of someone else)

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| **Name:** |
| **Job Title:** |
| **Address:** |
| **Connection with incident:** |
| **Does the person involved in the incident work in your organisation?** Yes  No  **If not, in what capacity were they there?** |
| **Signature** (if completed by hand):  **Date form completed:** |

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| **Employer Use ONLY** |
| **Reported to RIDDOR?** Yes  No  **If YES, how was it reported?** Telephone  Online  **Date Reported:** |
| **Action taken:** |
| **Date:** |
| **Name:**  **Signature** (if completed by hand): |