

Adult Accident/Incident Report Form

Name	
Location	
Date	Time
Briefly describe what you were doing at the time of the accident.	
If an injury was sustained, please indicate type of injury Bruising, Sprain, Dislocation, scald) Please indicate part of the body most seriously injured (i.e. ankle, eye, head/neck etc)	
Were there any witnesses? If so, please give contact details: <hr/>	
Treatment Details	
<input type="checkbox"/> None <input type="checkbox"/> First Aid <input type="checkbox"/> Hospital A&E <input type="checkbox"/> Occupational Health or Medical Centre <input type="checkbox"/> Advised to see own GP <input type="checkbox"/> Other – Please give details	
Consequences of the Accident	
Absence from work <input type="checkbox"/> If so for how many days?	
Was the absence certified?	
Date returned to work <hr/>	
Signature:	
Date:	