



## Health and safety incident report form

The incident	
Reported by	Department
Email	Phone                      Ext
Date of occurrence	Time
Exact location	
Accident <input type="checkbox"/> Incident <input type="checkbox"/> Near miss <input type="checkbox"/> Violence <input type="checkbox"/> Ill health <input type="checkbox"/> Safety <input type="checkbox"/>	
What happened? Report any details that may have contributed to the incident (i.e., poor lighting). Use additional paper as necessary and attach to form.	
Describe the outcome: harm/health effects/damage.	
Describe corrective measures taken to address immediate hazards related to incident.	

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The affected person		
Worker <input type="checkbox"/> other: (i.e., visitor, contractor) <input type="checkbox"/>		Name
Address		Date of birth
Email—work:		Email—home
Employer’s name if other than worker	Address	Phone
Witness details		
Names(s) and contact information		Names(s) and contact information
First aid		
First aid provided: Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>		Time of attendance:
By whom:		Contact information:
Details of provision:		

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3

Post incident
Where did the person involved in the incident go next? To the hospital <input type="checkbox"/> home <input type="checkbox"/> returned to work <input type="checkbox"/> other <input type="checkbox"/>
Was a member of the joint health and safety committee notified of the incident?    Yes <input type="checkbox"/> No <input type="checkbox"/>
Name:

**Additional notes:**