**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): |