



ACCIDENT / INCIDENT REPORT

Complete as soon as possible after the accident or incident.
(Manager/supervisor to complete if staff member unable to do so and check accuracy of information)

Report to Able Personnel

For non-injury accidents complete questions 1, 2, 3, 4, 8, 9, 10, 13 & 14 as applicable

1 Particulars of employer:

Company	ABLE Personnel Services Ltd
Client	

2 Location of place of accident/incident:

Location	
Department	

3 Personal data of injured person:

Name	
Residential Address	

Date of Birth		<input type="checkbox"/> Male	<input type="checkbox"/> Female
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4 Signature of injured person:

	Date:
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5 Occupation or job title of injured person:

<input type="checkbox"/> Temp	<input type="checkbox"/> Perm	<input type="checkbox"/> Visitor

6 Period of employment of injured person:

- 1st week 1st month 1-6 months
 6 months - 1 year 1-5 years Over 5 years
 non-employee

7 Treatment of injury:

- Nil First-aid [= Harm]
 Doctor (not hospitalised) Hospitalised [= Poss Serious Harm]

8 Time and date of accident / harm:

Date		Time	am / pm
Started work at (time)			

If shiftworker: Shift Day Afternoon Night

9 Mechanism of accident / harm:

- Fall, trip or slip Hitting objects with part of the body
 Sound or pressure Being hit by moving objects
 Body stressing Heat, radiation or energy
 Biological factors Chemicals or other substances
 Mental stress

NB For serious harm injuries: Secure the accident site and ensure it is not disturbed pending possible DoL investigation.
Notify the Branch Manager. Mobile 027 631 5525 or 06 878 0026

Office use only – Branch Manager to complete

Do you accept this as a work related injury? Yes No Unsure

I, the undersigned, declare that the details above have been completed accurately, truthfully and fully to the best of my knowledge and belief, and I understand that providing a false or misleading statement is an offence.

Signature of Branch Manager:		Date:	
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10 Agency of accident / harm:

- Machinery or (mainly) fixed plant
 Mobile plant or transport
 Powered equipment, tools or appliances
 Non-powered hand tools, appliances and equipment
 Chemical or chemical products
 Material or substance
 Environmental agency
 Animal, human or biological agency (not bacteria or virus)
 Bacterial or virus

11 Body part:

- Head Neck Trunk
 Upper limb Lower limbs Multiple locations
 Systemic (internal organs)

12 Nature of injury or disease: (Specify all)

- Sprain or strain Amputation, incl. eye
 Open wound Nerves or spinal cord
 Puncture wound Damage to artificial aid
 Bruising or crushing Disease, nervous system
 Foreign body Disease, musculoskeletal
 Burns Disease, skin
 Poisoning & toxic effects Disease, digestive system
 Fracture of spine Disease, infectious or parasitic
 Other fractures Disease, respiratory system
 Multiple injuries Disease, circulatory system
 Superficial injury Tumour (malignant or benign)
 Dislocation Mental disorder
 Head injury Fatal
 Internal injury of trunk Occupational hearing loss

13 How did the accident / harm happen?

(If not enough room attach separate sheet or sheets.)

14 Was a significant hazard involved? Yes No
[Refer to department's Hazard Register]

15 Has an investigation been carried out? Yes No
[Required if significant hazard involved or if serious harm injury]

Signature of Head of Department/Manager:

	Date:
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Name:
