Dorset Council

Accident/Incident Report Form

Appendix 2

		F2508:

Details of affected person

Surname ______________________ **Forename(s)** ______________________

Date of Birth ____________ **Male** ☐ **Female** ☐ **Job Title** ______________________

Workplace/Service Area ______________________

Home Address

Postcode Telephone

Employers name & address (if not DC)

Postcode Telephone

Was more than one person injured in the same incident? Yes ☐ No ☐

Type of incident

- ☐ Accident
- ☐ Violence (Actual)
- ☐ Violence (Threat)
- ☐ Dangerous Occurrence
- ☐ Work Related Disease

Injured/affected person

- ☐ DC Employee
- ☐ Service User
- ☐ Pupil
- ☐ Contractor / Agency
- ☐ Member of Public

Directorate

- ☐ People – Children's
- ☐ Corporate Development
- ☐ Place
- ☐ People - Adults

To whom was the incident first reported?

Name: ______________________

Post held: ______________________

Date/Time: ______________________

Location of incident ______________________

If incident happened away from establishment/base, give details. (eg. service users house/public place/at someone else's premises) Precise place of incident e.g. stairs, corridor ______________________

Incident details Date of incident ____________ Time of incident ____________ am/pm ____________

What was the incident & how did it happen? (If insufficient space attach details on separate sheet)

Injury - What injury resulted state cut, bruise, fracture. Indicate left/right

Time lost - Did incident result in injured/affected person's absence/inability to undertake normal duties Yes ☐ No ☐

Inform the Health & Safety Team by phone if more than 3 days off work has elapsed 01305 224296

Details of any witness(s)

Name, address, telephone no. (if not DCC employee)

Details of assailant(s) (if violent incident)

Action taken

- ☐ No action required
- ☐ First aid on site
- ☐ Sent or taken home
- ☐ Attended Doctor or Health Centre
- ☐ Sent or taken to hospital
- ☐ Detained in hospital over 24hr

Report completed by:

Name: ______________________

Job title: ______________________

Date: ______________________

What action has been taken to prevent a recurrence: (Line Manager to complete, use separate sheet if necessary)

Name: Signature: Date:

White copy to be sent to the Health and Safety Team, County Hall. Yellow copy to be held in the workplace.

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