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Team Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Report of an Accident, Injury, or Dangerous Occurrence

This form is to be completed in order to report any accident, injury, or dangerous occurrence, which occurs on the University of Worcester Campus or in the course of University of Worcester activities away from the Campus.

It therefore applies to staff and students involved in field work, vocational placements and other work experience. It also applies to all visitors, conference delegates and contractors.

The form should be completed as comprehensively as possible immediately after the accident or incident and forwarded to the Health & Safety Co-ordinator in the Personnel Department; please leave blank any of the questions that cannot be immediately answered.

The supervisor, manager or tutor of the person experiencing the accident or dangerous occurrence, or by the person who took control at the time of the incident should complete the form.

**\***The section on date of birth, gender etc is for internal statistical purposes only, however for an accident to a visitor the date of birth is required.

**If copying this form please do not copy anything onto the reverse of Page 1**

**1. Details of person experiencing the Accident/Injury or recording the Dangerous Occurrence**

|  |  |
| --- | --- |
| Family/Surname: | First/Given Name: |
| Address: |
| Post Code: | Phone No: |
| Staff: □ | Student: □ | Visitor: □ | Contractor: □ |
| **\***Date of Birth: | **\***Gender:  | **\***Disabled: | **\***Ethnic Origin: |
| Staff Department: | Reason for Visitor on Campus: |
| Student Number: | Contractor - Employers Address: |

**2. Details of the Accident, Injury, or Dangerous Occurrence.**

|  |  |
| --- | --- |
| Date: | Time: |
| Precise Location of the Event: |
| Detailed Account of what happened: |

# Information for Accidents Only

|  |
| --- |
| Nature of any injuries sustained: |

|  |  |  |
| --- | --- | --- |
| Was the person doing something authorized or permitted for the purposes of their work/study? | Yes | No |
| Did the event take place at a location and at a time where the person was authorized or permitted to be? | Yes | No |
| Between what hours was the injured person expected to work on the day of the event. | FROM | TO |
| State hours worked by the injured person on the day of the event. | FROM | TO |

Date on which the person returned to work/study:

Time lost as a result of the accident:

# 3 Response to the Event

|  |  |
| --- | --- |
| Person who administered First Aid |  |
| Treatment administered: |
| Was the person taken to Hospital?Which hospital? |  |
| By whom? |  |

**4. Recording the Event**

## For completion by the Health & Safety Co-ordinator or nominee

Date report received:

Date of investigation by Health & Safety Co-ordinator:

Details of any remedial action taken:

Date of copy to Finance Office for insurers:

Date of report to Health, Safety and Environment Committee:

Notified to HSE 🞎 Date Time Reference No.