



Franklin United

Accident Investigation Form

Name of organisation:		Department:	
PARTICULARS OF ACCIDENT			
Date:	Time:	Location:	Date reported:
DETAILS OF INJURED PERSON			
Name:	Age:	Date of accident:	Contact number:
Job title:	Address:		Length of employment:
Type of injury: Injured part of body:			
DAMAGED PROPERTY			
Property damaged:			
Nature of damage:			
THE ACCIDENT			
Describe what happened			
WHAT WERE THE CAUSES OF THE ACCIDENT?			
How bad could it have been?			
<input type="checkbox"/> Very serious	<input type="checkbox"/> Serious	<input type="checkbox"/> Minor	
What is the chance of it happening again?			
<input type="checkbox"/> Frequent	<input type="checkbox"/> Occasional	<input type="checkbox"/> Rare	
What has or will be done to prevent it occurring again in future?			
TREATMENT AND INVESTIGATION OF ACCIDENT			
Type of treatment given:		Name of first aider:	
Doctor/hospital:			
Accident investigated by:	Date:	OSH advised?	Date