

THE HIGHLAND COUNCIL

APPENDIX 1

FORM FOR THE REPORTING OF ACCIDENTS, INCIDENTS AND OCCUPATIONAL HEALTH

PLEASE COMPLETE ALL SECTIONS OF FORM- Enter X in appropriate boxes:

Ref. No. office use only

NATURE OF INCIDENT:-		COUNCIL AREA:-		SERVICE:-	
ACCIDENT/INCIDENT WITH INJURY <input type="checkbox"/> ACCIDENT/INCIDENT WITHOUT INJURY <input type="checkbox"/> ACT OF VIOLENCE <input type="checkbox"/> OCCUPATIONAL ILL HEALTH <input type="checkbox"/> NEEDLESTICK INJURY <input type="checkbox"/> ROAD TRAFFIC ACCIDENT <input type="checkbox"/> OTHER (PLEASE INDICATE) <input type="checkbox"/>		CAITHNESS, SUTHERLAND & EASTER <input type="checkbox"/> ROSS <input type="checkbox"/> INVERNESS, NAIRN, BADENOCH & STRATHSPEY <input type="checkbox"/> ROSS, SKYE & LOCHABER <input type="checkbox"/>		CHIEF EXECUTIVE <input type="checkbox"/> EDUCATION/CULT/SPORT <input type="checkbox"/> - CATERING & CLEANING <input type="checkbox"/> FINANCE <input type="checkbox"/> HOUSING <input type="checkbox"/> - BUILD / MAINT <input type="checkbox"/>	
				PLANNING / DEV LP <input type="checkbox"/> TEC SERVICES: <input type="checkbox"/> - TRANSPORT <input type="checkbox"/> - G GROUNDS/MAINT <input type="checkbox"/> - WASTE /REFUSE <input type="checkbox"/> SOCIAL WORK <input type="checkbox"/>	
DETAILS OF INJURED PERSON:-				DATE ACCIDENT HAPPENED	
NAME				TIME	
HOME ADDRESS				ADDRESS OF PREMISES WHERE ACCIDENT HAPPENED:-	
OCCUPATION				DATE NOTIFIED	
SEX M/F				TO WHOM	
STATUS:		EMPLOYEE		AGE	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		CONTRACTOR		DATE NOTIFIED	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		PUPIL		TO WHOM	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		CLIENT/PUPIL		NAMES & ADDRESSES OF ANY WITNESSES	
<input type="checkbox"/>		<input type="checkbox"/>		1 <input type="text"/>	
<input type="checkbox"/>		<input type="checkbox"/>		2 <input type="text"/>	
TYPE OF INJURY / ILL HEALTH:-				SITE OF INJURY:-	
NONE <input type="checkbox"/> DEATH <input type="checkbox"/> OVER 3 DAY ABSENCE <input type="checkbox"/> FRACTURE <input type="checkbox"/> DISLOCATION <input type="checkbox"/> BURN <input type="checkbox"/> SCALD <input type="checkbox"/> CUT /SCRATCH <input type="checkbox"/> PUNCTURE WOUND <input type="checkbox"/> BRUISE /SWELLING <input type="checkbox"/> OTHER <input type="checkbox"/>				HEAD <input type="checkbox"/> CHEST <input type="checkbox"/> ABDOMEN <input type="checkbox"/> BACK <input type="checkbox"/> INTERNAL <input type="checkbox"/> EYE <input type="checkbox"/> EAR <input type="checkbox"/> FACE <input type="checkbox"/> NECK <input type="checkbox"/> SHOULDER <input type="checkbox"/> UPPER ARM <input type="checkbox"/>	
LOSS OF LIMB <input type="checkbox"/> LOSS OF SIGHT <input type="checkbox"/> PARTIAL LOSS OF SIGHT <input type="checkbox"/> CONCUSSION <input type="checkbox"/> SHOCK <input type="checkbox"/> POISONING / GASSING <input type="checkbox"/> INTERNAL INJURY <input type="checkbox"/> HEARING IMPAIRMENT <input type="checkbox"/> DISEASE <input type="checkbox"/> IRRITATION <input type="checkbox"/> STRAIN /SPRAIN <input type="checkbox"/>				ELBOW <input type="checkbox"/> LOWER ARM <input type="checkbox"/> WRIST <input type="checkbox"/> HAND <input type="checkbox"/> FINGER <input type="checkbox"/> UPPER LEG <input type="checkbox"/> KNEE <input type="checkbox"/> LOWER LEG <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TOES <input type="checkbox"/>	
FIRST -AID TREATMENT YES / NO				IS RIDDOR NOTIFICATION REQUIRED? YES / NO	
GIVE DETAILS				F2508 / F2508A SENT TO HSE YES / NO (ATTACH COPY TO FORM)	
AGENT OF INJURY:-				CAUSE OF INCIDENT:-	
NONE <input type="checkbox"/> HIT BY MOVING OBJECT <input type="checkbox"/> ELECTRICITY <input type="checkbox"/> MACHINERY(Powered) <input type="checkbox"/> MACHINERY(Hand held) <input type="checkbox"/> SLIP,TRIP OR FALL <input type="checkbox"/>				NONE <input type="checkbox"/> UNSAFE ENVIRONMENT <input type="checkbox"/> UNSAFE MACHINERY <input type="checkbox"/> UNSAFE STACKING <input type="checkbox"/> UNSAFE SYSTEM OF WORK <input type="checkbox"/> MISUSE OF EQUIPMENT <input type="checkbox"/> MANUAL HANDLING <input type="checkbox"/> HORSEPLAY <input type="checkbox"/>	
HANDLING / LIFTING <input type="checkbox"/> HAZARDOUS SUBSTANCE <input type="checkbox"/> PRESSURE SYSTEM <input type="checkbox"/> HEAT OR COLD <input type="checkbox"/> ANIMAL / INSECT <input type="checkbox"/> HUMAN <input type="checkbox"/> OTHER <input type="checkbox"/>				PROTECTIVE EQUIPMENT <input type="checkbox"/> INADEQUATE <input type="checkbox"/> NOT WORN <input type="checkbox"/> INADEQUATE / SUB STANDARD <input type="checkbox"/> TRAINING <input type="checkbox"/> INSTRUCTION <input type="checkbox"/> SUPERVISION <input type="checkbox"/> OTHER <input type="checkbox"/>	
BRIEF DESCRIPTION OF INCIDENT: ATTACH ADDITIONAL SHEETS AS REQUIRED					
RECOMMENDATIONS/OBSERVATIONS ON REMEDIAL MEASURES TAKEN TO PREVENT RECURRENCE: - INDICATE DATES ETC.					
DATE INCAPACITATION COMMENCED		DATE OF RETURN (IF KNOWN)		TOTAL ABSENCE	
ANY PROPERTY/ASSET DAMAGE		ESTIMATED COSTS			
SIGNATURE OF PERSON COMPLETING FORM				PRINT NAME	
ADDRESS & OCCUPATION IF NOT INJURED PERSON					
I HEREBY DECLARE THAT THE INFORMATION CONTAINED IN THIS REPORT IS TRUE AND NO MATERIAL INFORMATION WITHIN MY KNOWLEDGE IN REGARD THERETO HAS BEEN WITHHELD.					
INVESTIGATING OFFICER/SUPERVISOR SIGNATURE:					
ORIGINAL		DATE		TELEPHONE	
TO BE RETAINED LOCALLY					
DUPLICATE		SEND TO HEALTH AND SAFETY TEAM			

PERSONS COMPLETING FORM SHOULD ENSURE THAT ALL RELEVANT COPIES OF FORMS AND ADDITIONAL SHEETS ARE ATTACHED BEFORE DISPATCH.