ACCIDENT REPORT FORM

Company Name: _____
Location/Site: _____
Department: _____
Date of Report: ____ / ____ / _____
Reported By: _____
Contact Number: _____

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1. Accident Details

- **Date of Accident:** ____ / ____ / _____
- **Time of Accident:** _____ AM / PM
- **Location of Accident:** _____
- **Type of Incident:**
  ☐ Fall from Height
  ☐ Slip/Trip
  ☐ Caught in/Between
  ☐ Struck by Object
  ☐ Electrical
  ☐ Chemical Exposure
  ☐ Fire/Explosion
  ☐ Other (Please specify): _____

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2. Persons Involved

Name of Injured Person: _____
Designation/Job Title: _____
Gender: ☐ Male ☐ Female
Age: _____
Employee ID (if applicable): _____
Contact Number: _____

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3. Description of the Accident

Provide a detailed description of what happened (include sequence of events):

_____
_____
_____
_____
_____

4. Injury Details

- **Type of Injury:**
  ☐ Bruise
  ☐ Cut/Laceration
  ☐ Fracture
  ☐ Burn
  ☐ Sprain/Strain
  ☐ Internal Injury
  ☐ Eye Injury
  ☐ Other: _____
- **Body Part Affected:** _____
- **First Aid Given:** ☐ Yes ☐ No
  If yes, specify treatment: _____
- **Hospitalization Required:** ☐ Yes ☐ No
- **Name of Hospital (if applicable):** _____

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5. Witnesses (if any)

Name Contact Number Statement Taken (Yes/No)

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6. Cause of the Accident

Describe the root cause(s):

☐ Unsafe Act
☐ Unsafe Condition
☐ Lack of PPE
☐ Inadequate Training
☐ Poor Housekeeping
☐ Equipment Failure
☐ Others (Specify): _____

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7. Corrective/Preventive Actions Taken

Actions Taken Immediately After the Accident:

Recommendations to Prevent Recurrence:

Responsible Person: _____
Target Completion Date: ____ / ____ / _____

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8. Supervisor/Manager Comments

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9. Signatures

Injured Person (if applicable): _____ Date: ____ / ____ / _____
Witness (if applicable): _____ Date: ____ / ____ / _____
Supervisor/Manager: _____ Date: ____ / ____ / _____
Safety Officer: _____ Date: ____ / ____ / _____