



A) Details of the Researcher/Student

1. Name	:	
2. Roll Number / Admission No.	:	
3. Details of Supervisor, if any	:	

B) Details of Accident

1. Place of Incident	:	
2. Date of Incident	:	Time of Incident :
3. Incident Reported Date	:	
4. Have you taken First-Aid	:	
6. If Yes, Details of First Aider	:	

C) Nature and extend of Injury

Part of body injured	<input type="checkbox"/> Head	<input type="checkbox"/> Trunk	<input type="checkbox"/> Multiple
	<input type="checkbox"/> Eyes	<input type="checkbox"/> Arm	<input type="checkbox"/> General
	<input type="checkbox"/> Neck	<input type="checkbox"/> Leg	<input type="checkbox"/> Unspecified
Nature of injury	<input type="checkbox"/> Sprain	<input type="checkbox"/> Laceration/Deep Cut	<input type="checkbox"/> Burn
	<input type="checkbox"/> Fracture	<input type="checkbox"/> Temp.Unconsciousness	<input type="checkbox"/> Superficial
	<input type="checkbox"/> Multiple	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Amputation
	<input type="checkbox"/> Bruise	<input type="checkbox"/> Other	<input type="text"/>
Type of incident	<input type="checkbox"/> Flying object	<input type="checkbox"/> Manual handling	<input type="checkbox"/> Electricity
	<input type="checkbox"/> Struck by	<input type="checkbox"/> Poisons	<input type="checkbox"/> Fall
	<input type="checkbox"/> Caught in	<input type="checkbox"/> Temperature	<input type="checkbox"/> Other
Describe the events leading up to the injury and how the injury occurred (witness or injured person's statement).			

Name and Signature of the Student/Researcher or Accident Reporter

Accident Investigation – Investigator's Report

Details of the Witness

How did the accident happen

What caused the accidents

- | | | |
|---|---|---|
| <input type="checkbox"/> Ineffective guarding | <input type="checkbox"/> Lack of protective equipment | <input type="checkbox"/> Lack of training |
| <input type="checkbox"/> Lack of maintenance | <input type="checkbox"/> Safety rules not followed | <input type="checkbox"/> inexperience |
| <input type="checkbox"/> Unsafe work methods | <input type="checkbox"/> Misconduct | <input type="checkbox"/> Workplace design (equipment, design, layout) |
| <input type="checkbox"/> Weather | <input type="checkbox"/> Poor housekeeping | <input type="checkbox"/> Language difficulties |

How can a recurrence be prevented?

Date of Investigation :

Name and Signature of the Investigator