ACCIDENT/INCIDENT REPORT FORM

This form must be completed by the School/Department Head, Chief Technician, School/Unit Safety Officer or Supervisor/Manager as soon as possible after any incident has occurred/reported. This is a requirement under the College’s Employer & Public Liability policies. In the case of personal injuries, the original form should be retained by the Department, and copies emailed to insurance@tcd.ie.

Name: .......................................................... Staff □  Student □  Other □  Visitor □

Department: .............................................................................................................................

Job Title: ........................................ Hours of Work: ....................................................................

Date & Time of Alleged Accident: ..............................................................................................

Place/Building Name: ................................................................................................................

Grade of Accident:  Minor □  Moderate □  Severe □

Brief Particulars:
................................................................................................................................................
................................................................................................................................................
................................................................................................................................................
................................................................................................................................................

(Continue overleaf if necessary)

Nature of Injury: ............................................................................................................................

(If to limb or eye, state whether left or right) ..................................................................................

What action was taken to treat or minimize injury or damage?
..................................................................................................................................................

Did the injured party require an ambulance or lose consciousness?
....................................................................................................................................................
Please state the names & addresses of any witnesses:

(1) ……………………………………………………………………………………………………………………………………………………………………………………………

(2) ……………………………………………………………………………………………………………………………………………………………………………………………

Are you satisfied that an accident occurred at the time, date and place stated?
  Yes ☐ No ☐ N/A ☐

Was the person authorized to be in that place at that time for the purpose of his/her work?
  Yes ☐ No ☐ N/A ☐

What was the person doing at the time of the accident?

…………………………………………………………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………………………………………………

Was this something authorized or permitted to be done for the purpose of his/her work?
  Yes ☐ No ☐ N/A ☐

Was time taken off work as a result of this accident/incident? …………………………………………………………………………………………
  ● If so, how many days? ……………………………………………………………………………………………………………………………………………

To whom was the accident reported? ……………………………………………………………………………………………………………………………

When was it first reported? ……………………………………………………………………………………………………………………………………………

Signed: ……………………………………………………… Date: …………………………………………………………………

*Minor = Onsite treatment; Moderate = First aid and referred for medical attention; Severe = ambulance called.

Print Name: ……………………………………………… Ext No: …………………………………………………………………