**ACCIDENT REPORT**

Please complete the report below indicating the details of the accident that took place.

| | |
|---|---|
| **Name of employee** | |
| **Date of accident** | |
| **Time of accident** | |
| **Description of accident** | |
| **What caused the accident?** | |
| **Corrective action required** | |
| **Any discomfort/pain that the Employee is experiencing as a result of the accident?** | |
| **Actions required (e.g. medical examinations, etc.).** | |

Please submit all medical reports relating to the accident (if applicable) to the relevant Health & Safety Representative.

**Employee Signature** **Date**

**Witness Signature** **Date**