THE UNIVERSITY OF THE WEST INDIES

ST. AUGUSTINE, TRINIDAD & TOBAGO, WEST INDIES
Occupational Health, Safety and the Environment Unit
Telephone: (868) 662-2002 Exts. 82395/83138 Fax: 663-3132

INCIDENT/NEAR MISS FORM

Instructions:

1) This form (Pages 1&2) should be completed and sent to the OHSE Unit **within 24 hrs of the occurrence**.

2) The Supervisor or other authorized personnel should complete the form if the injured person is unable to do so.

SECTION 1 - PARTICULARS OF EVENT			
Please tick appropriate box: Accident ☐ Near Miss ☐ *(see NOTES on last page of form)*			
Date of Event *(dd/mm/yyyy)*:	Time of Event:	Weather Conditions:	
Location of Event:			
Event Reported to Supervisor/Head of Department? Yes ☐ No ☐	To:……. Time:…….. Date:……...	By:……. Date: ……	
Person completing this report: Name: …… Signature: ……Date *(dd/mm/yyyy)*:……			
SECTION 2 - TYPE OF EVENT (TICK ONE OR MORE THAN ONE WHERE APPLICABLE)			
Injury to person (s) ☐	Damage to property / equipment ☐	Vehicular ☐	Environmental ☐
Other (specify)			
SECTION 3 – PARTICULARS OF INJURED PERSON (FILL OUT A SEPARATE SHEET FOR EACH INJURED PERSON)			
Name:			Date of Birth *(dd/mm/yyyy)*:
Injured Person is *(please tick):* Staff ☐ Student ☐ Contractor ☐ Visitor ☐ *If injured person is a contractor, please give the name of the company as well.*			Occupation/Job Description:
Address:			Department:
ID/DP/PP number:	Telephone:		Email:
Start date of Employment *(dd/mm/yyyy*:	Nationality:	Gender: M ☐ F ☐	No. of days away from work:
Injury Sustained (if any):			
Signature:			Date:

Name(s) of Witness(es) Present (Print name):	**Department**	**Occupation**	**Telephone**

SECTION 4 – VEHICLE/ EQUIPMENT INVOLVED

Vehicle Registration Number / Equipment Type	Model / Serial Number	Authorized Operator / Driver (Print name)	Owner / Supplier of Vehicle or Equipment	Damages

SECTION 5 - DETAILS OF EVENT (State in detail what happened and if any first aid / medical treatment was administered.)

IF INJURY OCCURRED, PLEASE CHECK ONE:

- ☐ No First-Aid administered, returned to work
- ☐ First-Aid administered, returned to work
- ☐ Saw a physician, returned to work
- ☐ Saw a physician, returned to light duty
- ☐ Saw a physician, time loss
- ☐ Refused medical treatment

SECTION 6 - DETAILS OF MEDICAL

Name of Attending Physician:	Telephone:	Date of Diagnosis: *(dd/mm/yyyy)*:

Name and Address of Hospital or Clinic:

SECTION 7 - IMMEDIATE CAUSES / UNDERLYING / ROOT CAUSE OF EVENT

SECTION 8 - IMMEDIATE CORRECTIVE ACTION TAKEN

SECTION 9 - RECOMMENDATIONS BY SUPERVISOR

SUPERVISOR (Print Name):	**SIGNATURE:**	**DATE** *(dd/mm/yyyy)***:**

SECTION 10 - RECOMMENDATIONS BY OHSE MANAGER

FOR OFFICIAL USE:

OHSE MANAGER (Print Name):	**SIGNATURE:**	**DATE** *(dd/mm/yyyy)***:**

NOTES:

1) ***Incident:*** *is defined as an unplanned event that causes injury to person(s), damage to property or a combination of both. These include Spills (Laboratory and General Environment) and vehicular accidents.*
2) ***Near Miss:*** *is an unplanned event that* ***does not*** *result in injury or damage to property but* ***has the potential*** *to do so.*
3) ***First Aid:*** *Simple emergency treatment administered to an injured or sick person before professional medical care is available.*
4) ***Medical Treatment:*** *Professional treatment for illness or injury.*