The Mico University College

ACCIDENT / INCIDENT REPORT

This form shall be used to report any accident/incident on any campus of The Mico that has resulted in injury to a person(s) or in damage to property/equipment. The Supervisor / Manager is required to complete section F.
The completed form must be returned to the Human Resource Department within 48 hours of the Accident/Incident

A. DETAILS OF PERSON MAKING THE REPORT OTHER THAN THE INJURED PARTY

Name: _____ Staff / Student / Visitor / Contractor (*Please circle one*)

Faculty / Department : _____

Job Title (*if Staff*) _____ ID NO. (*If Student*) _____

Contact Telephone _____ *Cell* _____ *Home* _____ *Work*

B. DETAILS OF INJURED PERSON

Name: _____ Staff / Student / Visitor / Contractor (*Please circle one*)

Faculty / Department : _____

Job Title (*if Staff*) _____ ID NO. (*If Student*) _____

Address: _____

e-mail Address _____

Contact Telephone _____ *Cell* _____ *Home* _____ *Work*

Date of Birth _____ Gender ☐ Female ☐ Male

C. DETAILS OF ACCIDENT / INCIDENT

Date of Accident/Incident: _____ Time _____ a.m./p.m.

Location of Accident/Incident _____

Description of Accident / Incident _____

_____

_____

Was the accident/incident witnessed? ☐ Yes ☐ No

If "YES Name the witness _____

Address of witness _____ Contact No. _____

D. DETAILS REGARDING INJURY

Nature of Injury: _____

Was medical attention sought? ☐ Yes ☐ No

If "NO" was attention not required or desired? ☐ Not required ☐ Not desired

If "YES" Name of physician / hospital _____

Address Physician / Hospital _____ Contact No. _____

E. CONTACT INFORMATION OF NEXT OF KIN OF INJURED PARTY
(To be completed only if there is a need to contact the Next of Kin)

Name of Next of Kin: _____

Relationship: _____

Address: _____

Contact Telephone _____ *Cell* _____ *Home* _____ *Work*

F. DETAILS REGARDING DAMAGE TO PROPERTY/EQUIPMENT

Faculty / Department : _____

Property / Equipment Type : _____

Nature of damage : _____

The person making the report is required to sign the declaration below:

Declaration: The above report provides a true, accurate and complete account of the accident/incident

_____ *Name* _____ *Signature* _____ *Date*

G. DETAILS OF MANAGEMENT RESPONSE

The accident/incident reported overleaf was immediately reported to me ☐ Yes ☐ No

Indicate your opinion of the causative factors of this accident/incident

_____

_____

_____

_____

Indicate how this accident/incident can be prevented from recurring.

_____

_____

_____

_____

_____	_____	_____
Name of Manager / Supervisor	*Signature of Manager / Supervisor*	*Date*

H. FOR USE BY THE HR DEPARTMENT

The accident/incident has been reported to the Insurance Company

Name of Insurance Company _____

Address of Insurance Co. _____

Date Information sent _____

_____	_____	_____
Name HR Representative	*Signature HR Representative*	*Date*

I. FOR THE USE OF THE HEALTH AND SAFETY COMMITTEE

Date information submitted to the OSH Committee _____

New Hazard Identified ☐ Yes ☐ No

If "YES". Is the Hazard significant? ☐ Yes ☐ No

If "YES". Can the Hazard be Eliminated / Isolated / Minimized ? ☐ Eliminated ☐ Isolated ☐ Minimized

Details of action to be taken _____

_____

_____

_____

_____

_____	_____	_____
Name OSH Representative	*Signature OSH Representative*	*Date*