

**GA19 Accident report**

Company name		Project title	
Location		Contract no.	
1. Name of employer			
2. Site address			
		Contact name	
3. Injured person's surname		Forenames	
4. Injured person's address			
5. Normal occupation			Date of birth
6. Occupation at time of accident			
7. Exact location of accident			
8. Date and time of accident		Date	Time
9. Date and time of ceasing work		Date	Time
10. Precise nature of injury <i>(if eye or limb, state left or right)</i>			
11. To whom was the accident reported?			
		Date	Time
12. HSE or Incident Contact Centre informed by telephone or online			
Telephone	Online	Date	Time
13. F2508 report sent to the HSE on		Date	Time
14. Accident recorded in the official company register <i>(if applicable)</i>			Yes <input type="checkbox"/> No <input type="checkbox"/>
15. Was first aid given on site? If 'Yes' state name of first aider			Yes <input type="checkbox"/> No <input type="checkbox"/>
If treatment was received from a doctor, state doctor's name			
16. Did the injured person go to hospital?			Yes <input type="checkbox"/> No <input type="checkbox"/>
Give name of hospital			
17. Was the injured person authorised to be at the place of the accident for the purpose of their work?			Yes <input type="checkbox"/> No <input type="checkbox"/>
18. How was the accident caused?			
a) Give a full description of what happened			
b) State what the injured person was doing at the time			
c) If the person fell from height or into an excavation, state distance of fall in metres			m

**GA19 Accident report *continued***

19. What action has been taken to prevent a recurrence?							
20. Was machinery involved?							
a) Give name and number of machine or part involved in the accident							
b) Was it working at the time of the accident?						Yes	No
21. Names and addresses of witnesses to the accident <i>(always obtain witnesses, where possible)</i>							
a)							
b)							
c)							
<i>Attach signed statements from each witness whenever possible</i>							
22. Use a separate sheet of paper for a sketch plan of the scene							
Name		Position		Signature		Date	

To be completed by Head Office							
Further medical reports on injured person				Yes	No	Date	
Injured person ceased employment				Yes	No	Date	
New address for injured person							
Is a further investigation report required?				Yes	No		
Have control measures been implemented to prevent a reoccurrence?				Yes	No	Date	