

## UNIVERSITY ACCIDENT REPORT FORM

- (i) Name of person involved in accident: \_\_\_\_\_
- (ii) Staff/Student ID Number: \_\_\_\_\_
- (iii) Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_
- (iv) Occupation: \_\_\_\_\_
- (v) Employed at the University of Limerick: Yes: ☐ No: ☐
- (vi) If an employee of the University please state Department: \_\_\_\_\_  
\_\_\_\_\_
- (vii) If no, please elaborate: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- (viii) Particulars of accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- (ix) Place: \_\_\_\_\_
- (x) Time: \_\_\_\_\_ Date: \_\_\_\_\_
- (xi) Witnesses: \_\_\_\_\_ Phone No.: \_\_\_\_\_  
Address: \_\_\_\_\_  
Witness: \_\_\_\_\_ Phone No.: \_\_\_\_\_  
Address: \_\_\_\_\_  
Record names, addresses and phone numbers of other witnesses overleaf

(xii) When and to whom was the accident initially reported: \_\_\_\_\_

\_\_\_\_\_

(xiii) Particulars of accident: circumstances under which it occurred: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

use additional pages if necessary

(xiv) Details of injury:

- |  |  |
|--|--|
| <input type="checkbox"/> Bruising, contusion               | <input type="checkbox"/> Suffocation, asphyxiation   |
| <input type="checkbox"/> Concussion                        | <input type="checkbox"/> Gassing                     |
| <input type="checkbox"/> Internal injuries                 | <input type="checkbox"/> Drowning                    |
| <input type="checkbox"/> Open wound                        | <input type="checkbox"/> Poisoning                   |
| <input type="checkbox"/> Abrasion, graze                   | <input type="checkbox"/> Infection                   |
| <input type="checkbox"/> Amputation                        | <input type="checkbox"/> Burns, scalds and frostbite |
| <input type="checkbox"/> Open fracture (i.e. bone exposed) | <input type="checkbox"/> Effects of radiation        |
| <input type="checkbox"/> Closed fracture                   | <input type="checkbox"/> Electrical injury           |
| <input type="checkbox"/> Dislocation                       | <input type="checkbox"/> Injury not ascertained      |
| <input type="checkbox"/> Sprain, torn ligaments            | <input type="checkbox"/> Other, please specify _____ |

(xv) Indicate part of body most seriously injured (put an 'x' in one box only)

- |  |   |
|--|---|
| <input type="checkbox"/> Head, except eyes | <input type="checkbox"/> Fingers, one or more         |
| <input type="checkbox"/> Eyes              | <input type="checkbox"/> Hip joint, thigh, knee cap   |
| <input type="checkbox"/> Neck              | <input type="checkbox"/> Knee joint, lower leg, ankle |
| <input type="checkbox"/> Back, spine       | <input type="checkbox"/> Foot                         |



- |   |  |
|---|--|
| <input type="checkbox"/> Chest                      | <input type="checkbox"/> Toes, one or more           |
| <input type="checkbox"/> Abdomen                    | <input type="checkbox"/> Extensive parts of the body |
| <input type="checkbox"/> Shoulder, upper arm, elbow | <input type="checkbox"/> Multiple injuries           |
| <input type="checkbox"/> Lower arm, wrist, hand     | <input type="checkbox"/> Other, Please specify_____  |

(xvi) Consequences of the accident

Fatal	Date of resumption of work if back			Anticipated absence if not back
	back			4-7 days
Non Fatal	Day	Month	Year	8-14 days
	_____	_____	_____	More than 14 days

(xvii) Treatment\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(xviii) Doctors report and recommendation\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of person completing report: \_\_\_\_\_ Date

Print name and job title

Signature of Head of Department:\_\_\_\_\_ Date:

Printname:\_\_\_\_\_

(Copies of the completed University Accident Report are to be sent to the Safety Officer and the Buildings & Estates Department)