# **University Incident Report Form**

(Copies of the completed University Incident Report must be sent to the Safety Officer ([healthandsafetyquery@ul.ie](mailto:healthandsafetyquery@ul.ie)) and the Buildings Department [buildingsmaintenance@ul.ie](mailto:buildingsmaintenance@ul.ie))

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Name:** | | |  | | | |
| **Staff/ Student ID number:** | | |  | | | |
| **Staff  Student  Service Provider  Visitor** | | | | | | |
| **If a university staff member, specify department and job title:** | | | |  | | |
| **Contact phone number:** | | | |  | | |
|  | **Particulars of incident** (Please provide as much detail as possible including sketch, plan, photographs etc, (where feasible) | | | | | | |
| **When and to whom was the incident initially reported:** | | | | **When** | | **Whom** |
| **Location** |  | | | | | |
| **Time** | |  | | **Date** |  | |
| **Witness Name** | |  | | **Phone number** |  | |
| *(Record names, and phone numbers of additional witnesses overleaf)* | | | | | | |
| **What immediate action (if any) has been taken to make safe/prevent a reoccurrence?** | | | | | | |

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|  | **Details of injury (please tick as appropriate)** | | |
| No injury sustained | Bruising, contusion | |
| Concussion | Gassing | |
| Internal injuries | Drowning | |
| Open wound | Poisoning | |
| Abrasion, graze | Infection | |
| Amputation | Burns, scalds or frostbite | |
| Open fracture (i.e. bone exposed) | Effects of radiation | |
| Closed fracture | Electrical injury | |
| Dislocation | Injury not ascertained | |
| Sprain, torn ligaments | Suffocation, asphyxiation | |
| Other, please specify |  | |
| **Indicate part of body most seriously injured (tick as appropriate)** | | |
| No injury sustained | Head, except eyes | |
| Eyes | Hip joint, thigh, kneecap | |
| Neck | Knee joint, lower leg, ankle | |
| Back, spine | Foot | |
| Chest | Toes, one or more | |
| Abdomen | Extensive parts of the body | |
| Shoulder, upper arm, elbow | Multiple injuries | |
| Lower arm, wrist, hand | Fingers, one or more | |
| Other, please specify |  | |
| **Consequences of the incident** | | |
| Fatal  Non-Fatal | | |
| **Treatment** | | |
| First Aid Given  No First Aid Given | | |
| Name of First Aid Responder | |  |
| Medical Aid Given  No Medical Aid Given | | |
| Treatment Details Provided if known: | |  |
| Date of resumption to work (if applicable) | |  |
| Anticipated absence from work (if applicable) | | No lost time  4-7 days  8-14 days  >14days |

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|  | **Incident Root Cause** *(Detail identified causes considered responsible for the adverse event)* | | |
| **Remedial Action Plan** (*List the actions that have already/will be put in place to reduce the risk of a future occurrence)* | | |
| **Action** | **Responsible Person** | **Required Completion Date** |
|  |  |  |

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| --- | --- | --- | --- |
| **Signature of person completing this report** |  | **Date** |  |
| **Print name and job title** |  | | |
| **Signature of Head of Department or alternate** |  | **Date** |  |
| **Print name and job title** |  | | |