# **University Incident Report Form**

(Copies of the completed University Incident Report must be sent to the Safety Officer (healthandsafetyquery@ul.ie) and the Buildings Department 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** |  |