

Report of an Injury, Disease or Dangerous Occurrence

The Health and Safety at Work etc. (Guernsey) Law, 1979: and
The Health and Safety at Work (General) (Guernsey) Ordinance 1987.

Ref: HSELicenceAppAFP



- All sections of this form must be completed.
- This form to be used to make a report to the Commerce and Employment Department under Section 9 of the Ordinance.
- Details of this incident should also be kept as required by Section 10 of the Ordinance.
- Completing and signing this form does not constitute an admission of liability of any kind, either by the person making the report or any other person.
- If more than one person was injured as a result of an accident, please complete a separate form for each person.

=====

A. Subject of report. (tick appropriate boxes).

| | | | | | | | | |
|----------------------|--------------------------|---|-------------------------------------|--------------------------|---|-------------------------|--------------------------|---|
| Fatality | <input type="checkbox"/> | 1 | Specified major injury or condition | <input type="checkbox"/> | 2 | "Over three day" injury | <input type="checkbox"/> | 3 |
| Dangerous occurrence | <input type="checkbox"/> | 4 | Disease | <input type="checkbox"/> | 5 | No time off work | <input type="checkbox"/> | 6 |

B. This form must be completed IN FULL by the Employer or Responsible Person (as is required by the Law).

| | |
|--|---|
| Name and address:- | Nature of trade, business or undertaking:- |
| <input type="text"/> | <input type="text"/> |
| Name and telephone number of person to contact:- | Immediate notification to Board (not applicable to "over three day" injuries) :- |
| <input type="text"/> | Name of person advised: _____ |
| | Date Time am/pm |

C. Date, time and place of accident, dangerous occurrence.

| | | | | | |
|---|----------------------|----------------------|----------------------|--------|----------------------|
| Date:- | <input type="text"/> | <input type="text"/> | <input type="text"/> | Time:- | <input type="text"/> |
| | Day | Month | Year | | |
| Give the name and address if different from above:- | <input type="text"/> | | | | |
| Normal activity carried on here:- | <input type="text"/> | | | | |

IF YOU ARE REPORTING A DANGEROUS OCCURRENCE PLEASE CONTINUE AT SECTION G.

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D. The person injured or affected by the disease.

Full name and address:-

Age:-

Sex:-

Status (tick box):-

Employee

Self Employed

Trainee

Any other person

Trade, occupation or job title:-

Nature of injury or condition and the part
of body effected.

In the case of a disease the name or
Schedule number of the disease:-

Doctor's name and date of diagnosis:-

Doctor:-

| | | |
|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| day | month | year |

IF YOU ARE REPORTING A DISEASE PLEASE CONTINUE AT SECTION H.

E. Kind of accident.

Indicate what kind of accident led to the injury or condition (tick one box) :-

Contact with moving
machinery or material
being machined.

1.

Injured whilst handling
lifting or carrying

5.

Trapped by
something collapsing
or overturning.

8.

Exposure to
an explosion

12.

Struck by moving
including flying or
falling object

2.

Slip, trip or fall
on same level.

6.

Drowning or
asphyxiation

9.

Contact with electricity
or an electrical
discharge

13.

Struck by moving
vehicle

3.

Fall from a height *

7.

Exposure to or contact
with a harmful
substance.

10.

Injured by
an animal

14.

Struck against something
fixed or stationary.

4.

* Distance through
which person fell

(meters)

Exposure to fire

11.

Other kind of
Accident (give
details in section H)

15.

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F. Agent(s) involved

Indicate which, if any, of the categories of agent or factor below were involved. (tick one or more boxes).

| | | | | | | | | | | | |
|--|--------------------------|----|---|--------------------------|----|--|--------------------------|-----|--|--------------------------|-----|
| Machinery/equipment For lifting and conveying | <input type="checkbox"/> | 1. | Process plant, pipework or bulk storage | <input type="checkbox"/> | 5. | Live animal | <input type="checkbox"/> | 9. | Ladder or scaffolding | <input type="checkbox"/> | 13. |
| Portable power or hand tools | <input type="checkbox"/> | 2. | Any material, substance or product being handled used or stored | <input type="checkbox"/> | 6. | Movable container or package of any kind | <input type="checkbox"/> | 10. | Construction formwork, shuttering and falsework | <input type="checkbox"/> | 14. |
| Any vehicle or associated equipment/ machinery | <input type="checkbox"/> | 3. | Gas, vapour, dust, fume or oxygen deficient atmosphere | <input type="checkbox"/> | 7. | Floor, ground, stairs or any working surface | <input type="checkbox"/> | 11. | Electricity supply cable, wiring, apparatus or equipment | <input type="checkbox"/> | 15. |
| Other machinery | <input type="checkbox"/> | 4. | Pathogen or infected material | <input type="checkbox"/> | 8. | Building, engineering structure or excavation/ underground working | <input type="checkbox"/> | 12. | Entertainment or sporting facilities or equipment | <input type="checkbox"/> | 16. |
| | | | | | | | | | Any other agent | <input type="checkbox"/> | 17. |

Describe briefly the agents or factors you have indicated:-

G. Dangerous occurrence. Reference number of dangerous occurrence:-

H. Account of accident, dangerous occurrence or flammable gas incident

Describe what happened and how. In the case of an accident state what the injured person was doing at the time.
In the case of a disease describe any work of the affected person which might be relevant to the onset of the disease.
Please use and attach extra pages if required

Signature of person making report:- _____ Date:- _____

The Health and Safety Executive, Commerce and Employment Department, PO Box 459, Longue Rue, St. Martins, Guernsey GY1 6AF