# Workplace Accident Record Form

## Employee Information

Full Name

Employee ID / Number

Department

Contact Information

## Accident Details

Date and Time of Accident

Location of Accident

Description of Accident

Immediate Action Taken

## Injury / Damage Information

Type of Injury / Damage

First Aid Provided

Medical Treatment Required

Yes

Witnesses (Names & Contacts)

## Reporting

Reported To (Name & Position)

Date Reported

- Ensure all sections of this form are filled out promptly and accurately after any workplace accident.
- This document is crucial for workplace safety investigations and legal compliance.
- Personal information must be handled confidentially and according to data protection policies.
- Retain completed records as required by workplace safety regulations and company policy.