UNIVERSITY *of* LIMERICK

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: ☐
Put an 'x' in the appropriate box

(vi) If an employee of the University please state Department: ________________

____

(vii) If no, please elaborate: ____

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____

(viii) Particulars of accident:

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(ix) Place: ____

(x) Time: ______________________ Date: ___________________________

(xi) Witnesses: ________________________ Phone No.: ________________

Address: ____

Witness: ____________________________ Phone No.: ________________

Address: ____
Record names, addresses and phone numbers of other witnesses overleaf

UNIVERSITY OF LIMERICK
OLLSCOIL LUIMNIGH

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

____

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

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use additional pages if necessary

(xiv) Details of injury:

Indicate type of injury (put an 'x' in one box only)

- ☐ Bruising, contusion
- ☐ Concussion
- ☐ Internal injuries
- ☐ Open wound
- ☐ Abrasion, graze
- ☐ Amputation
- ☐ Open fracture (i.e. bone exposed)
- ☐ Closed fracture
- ☐ Dislocation
- ☐ Sprain, torn ligaments
- ☐ Suffocation, asphyxiation
- ☐ Gassing
- ☐ Drowning
- ☐ Poisoning
- ☐ Infection
- ☐ Burns, scalds and frostbite
- ☐ Effects of radiation
- ☐ Electrical injury
- ☐ Injury not ascertained
- ☐ Other, please specify______________________

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

- ☐ Head, except eyes
- ☐ Eyes
- ☐ Neck
- ☐ Back, spine
- ☐ Fingers, one or more
- ☐ Hip joint, thigh, knee cap
- ☐ Knee joint, lower leg, ankle
- ☐ Foot

- ☐ Chest
- ☐ Abdomen
- ☐ Shoulder, upper arm, elbow
- ☐ Lower arm, wrist, hand
- ☐ Toes, one or more
- ☐ Extensive parts of the body
- ☐ Multiple injuries
- ☐ Other, Please specify_____________________

(xvi) Consequences of the accident

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

(xvii) Treatment____

____

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____

(xviii) Doctors report and recommendation__________________________________

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Signature of person completing report: __________________________Date:________

Print name and job title:______________________________________

Signature of Head of Department:_______________________________ Date:_________

Print name:____

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