GOVERNMENT OF THE VIRGIN ISLANDS

HEALTH AND SAFETY INCIDENT REPORT

TODAY'S DATE _____D _____M _____Y

When to Use this Form

This form is to be used to report **all** work related accidents/incidents or circumstances that did or could have resulted in an accident or incident. An incident is referred to as a work-related event(s) in which an injury or ill health (regardless of severity) or fatality occurred, or could have occurred. A near-miss is an incident where no injury or illness occurred.. Therefore, an incident can be either an accident or a near-miss. An accident is regarded as a particular type of incident in which an injury or illness actually occurs.

Instructions (for persons involved in an incident)

1. Complete **Part A** (Supervisor/Manager may complete if the affected person is unable to do so).
2. Forward the completed form to your Supervisor/Manager.
3. Also, complete an Employment Injury Benefit form from Social Security (SSB) and submit to your Supervisor/Manager **(only in the event of an occupational injury or disease**).

Instructions (for Supervisor/Manager)

1. Ensure that Part A has been completed (Supervisor/Manager to complete if affected person is unable to do so).
2. Complete **Part B.**
3. Forward the completed form to the Health and Safety Unit, Department of Human Resources, **within 48 hours of the incident**.
4. Provide a copy of the completed form to the person involved in the incident.
5. Sign Employment Injury Benefit form from Social Security (SSB) and submit to (SSB) **within 30 days.**

PART A – TO BE COMPLETED BY PERSON INVOLVED INCIDENT

1. DETAILS OF PERSON INVOLVED IN AN INCIDENT

Status: Employee Contractor Visitor Other _____

Mr. Ms. Mrs. Dr. Other (Specify) _____

Name: _____ **Date of Birth:** _____

Department/Address: _____ **Supervisor:** _____

Position: _____ **Date of Employment:** _____

Contact Number (s): _____ **Email:** _____

Name of person completing form (if not affected person): _____

Position: _____ **Contact Number(s):** _____

2. DETAILS OF WITNESSES

Full Name: _____

Department/Address: _____ **Contact Number(s):** _____

3. DETAILS OF INCIDENT

Outcome: ☐ Accident ☐ Incident ☐ Illness

Exact date: _____ **Exact time:** _____

Exact location: _____

Describe what was being done at the time (e.g. driving a forklift, lifting bags of cement, typing). Use the additional sheet that is attached, if necessary.

_____

_____

_____

_____

Describe step by step how the incident happened (e.g. brakes failed, slipped on wet floor)
Please include the name of any particular chemical, product or equipment involved in the incident.

_____

_____

_____

_____

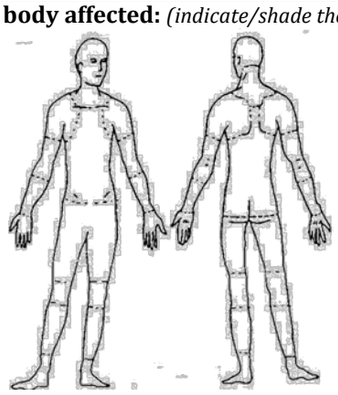
Why did this incident happen?
Choose the factor(s) which is the best explanation of why the incident occurred.

☐ Inadequate guard	☐ Operating without permission
☐ Unguarded hazard	☐ Operating at unsafe speed
☐ Defective safety device	☐ Making a safety device inoperative
☐ Defective tool or equipment	☐ Using defective equipment
☐ Hazardous workstation layout	☐ Using equipment in an unapproved way
☐ Unsafe lighting	☐ Unsafe lifting
☐ Unsafe ventilation	☐ Taking an unsafe position or posture
☐ Lack of needed personal protective equipment	☐ Distraction, teasing, horseplay
☐ Lack of appropriate equipment/tools	☐ Failure to wear personal protective equipment
☐ Unsafe clothing	☐ Failure to use the available equipment/tools
☐ No training or insufficient training	☐ Poor physical fitness

☐ Other: _____

4. DETAILS OF INJURY

Part of body affected: *(indicate/shade the area(s)*



☐Eye ☐Ear ☐Mouth ☐Neck ☐Shoulder

☐Arm ☐Elbow ☐Wrist ☐Hand ☐Finger/Thumb

☐Back ☐Knee ☐Hip/ Buttocks ☐Leg ☐Ankle

☐Foot ☐Toes ☐Chest/Trunk ☐Respiratory System

☐Internal organs (other than above) ☐Face (other than above)

☐Head (other than above) ☐Psychological System

☐Other: _____

Side of the body: ☐ Left side ☐ Right side

Nature of injury:

☐Abrasion	☐Burn (chemical)	☐Illness
☐Amputation	☐Concussion (to the head)	☐Sprain, strain
☐Broken bone	☐Crushing injury	☐Damage to a body system
☐Bruise	☐Cut, laceration, puncture	☐Other: _____
☐Burn (heat)	☐Hernia	_____

5. TREATMENT ADMINISTERED

Did you receive treatment? _____ **Where:** _____

By Whom? _____ **Contact Number:** _____

Treatment given: _____ **Date:** _____

_____

Officer's Signature: _____ **Date** _____

PART B – TO BE COMPLETED BY SUPERVISOR

6. INCIDENT INVESTIGATION

What contributed to this incident? (comment on the causes)

_____

_____

_____

_____

_____

7. CORRECTIVE AND PREVENTATIVE MEASURES

What changes do you suggest to prevent this incident from happening again?

PREVENTATIVE ACTIONS	PROPOSED	COMPLETED	PREVENTATIVE ACTIONS	PROPOSED	COMPLETED
Stop this activity	☐	☐	Train the employee(s)	☐	☐
Redesign task steps	☐	☐	Write a new policy/rule	☐	☐
Routinely inspect for the hazard	☐	☐	Provide personal protective equipment	☐	☐
Guard the hazard	☐	☐	Train the supervisor(s)	☐	☐
Redesign work station	☐	☐	Enforce existing policy	☐	☐

Other: _____

_____

What should be (or has been) done to carry out the proposed action(s) checked above? *Provide your comments/ recommendations on the preventative actions selected.*

Supervisor/Manager completing this form:

Name of Supervisor: _____ **Position:** _____

Date: _____ **Contact Number:** _____

Signature: _____

Please submit this completed form to the following address:

Department of Human Resources
Road Town, Tortola VG1110
British Virgin Islands
Telephone: 284-468-2178
Email: hrmail@gov.vg

FOR ADMINISTRATIVE USE ONLY

Processed by: _____ Date _____

Date follow-up completed: _____

Issues to consider: _____

Use this additional sheet to provide further details of the accident/incident or to provide any additional information.