



ACCIDENT ADVICE

RMS REF NO.: _____ DR NO.: _____ (if applicable)

To be completed by Risk Management Services for all work related accidents and forwarded to Human Resources:

N.B. Any statements from witnesses and/or diagrams, photographs, police reports etc., to be attached to this report.

DETAILS OF INJURED EMPLOYEE

SURNAME: _____ FIRST NAME/S: _____

IDENTITY NO.: _____ DATE OF BIRTH: _____

STAFF/STUDENT NO.: _____

OCCUPATION: _____

DEPARTMENT: _____

SEX: **MALE / FEMALE** (Please circle) _____ MARITAL STATUS: _____

LENGTH OF TIME EMPLOYED AT THE UNIVERSITY: _____

LENGTH OF EXPERIENCE IN PRESENT WORK: _____

RESIDENTIAL ADDRESS: _____

DETAILS OF ACCIDENT

DATE: _____ TIME: _____ PLACE: _____

DATE REPORTED: _____ REPORTED BY: _____

DESCRIPTION OF EVENTS (Indicate cause/s where possible): _____

NATURE OF INJURIES: _____

WITNESS/ES: 1. NAME: _____ TEL. NO.: _____
2. NAME: _____ TEL. NO.: _____

ADDITIONAL INFORMATION

DATE EMPLOYEE - CEASED WORK: _____

- RESUMED WORK: _____

REGISTRATION NO. (S) OF MOTOR VEHICLE (IF APPLICABLE): 1. _____
2. _____

ACCIDENT REPORTED TO POLICE? : YES/NO

FIRST AID GIVEN BY EMPLOYER? : YES/NO

DOCTOR'S NAME: _____

HOSPITAL'S NAME: _____

NAME(S) OF OTHER INJURED EMPLOYEES IF ANY: 1. _____
2. _____

REMARKS:

RISK MANAGEMENT SERVICES OFFICER ATTENDING:

NAME: _____ SIGNATURE: _____

DATE: _____

RISK MANAGEMENT SERVICES DIRECTOR

DATE

RECEIVED BY HUMAN RESOURCES:

SIGNED: _____

DATE: _____