

DF 02 Accident/Incident Reporting

Use this form to report any workplace accident, injury, incident, close call or illness. Return completed form to the Project Supervisor, or EHSS Department.

Report of:

- Lost Time/Injury First Aid Incident Accident Fatality

Date of incident	
Location	
Name of injured person (s)	
Employee Id of injured person (s)	
Details of the accident/injury	
Remedial action taken	
Name and phone number of EHSS representative/ project in charge present on site during the incident or remedial action	

Name of reporting person	
Date of reporting	
Signature	

History of amendments

The latest versions of the Documentation Format must be used at all times. This page needs to be updated whenever there is a change in the version number of the documents.

S. No	Date of amendment	Version	Details of amendment
1.	DD.MM.YYYY	01	Initial approval of the documentation format

Prepared by

Approved by