

# 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

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

|                                 |  |
|---------------------------------|--|
| <b>Name of reporting person</b> |  |
| <b>Date of reporting</b>        |  |
| <b>Signature</b>                |  |

## 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 |
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**Prepared by**

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**Approved by**