

ACCIDENT INVESTIGATION FORM

SITE	
DATE OF INCIDENT/TIME	
DATE REPORTED	
REPORTED TO	
AREA SUPERVISOR	

DETAILS OF INJURED PERSON/S DAMAGE TO PROPERTY.

Employee MOP Property Company vehicle

NAME _____
ADDRESS _____

D.O.B _____

HOME TEL NO:- _____

MOBILE TEL NO:- _____

INJURIES SUSTAINED OR TYPE OF DAMAGE CAUSES

	YES	NO
WAS FIRST AID OFFERED		
WAS FIRST AID RECEIVED		
WAS THE PERSON HOSPITALISED		

WHO PROVIDED FIRST AID _____

Days off work

