

APPENDIX 4
Incident / Accident Report Form

STATE OF QATAR
QATAR UNIVERSITY



INCIDENT / ACCIDENT REPORT FORM

INJURED PARTY/COMPLAINANT TO COMPLETE Sections A & B, **SIGN, DATE & SUBMIT** to your immediate supervisor/department within 24 HOURS of the event.

Section A: General Information (Injured Party/ Complainant)	
Last Name	First Name
Faculty/ Staff <input type="checkbox"/>	Student <input type="checkbox"/> Visitor <input type="checkbox"/> QU ID Number <input type="checkbox"/>
Department	Position
Telephone No.	Email
Section B: Description of the Event	
When Date of Event (MM/DD/YYYY)	Time of Event
Date Reported	Time Reported
Where Location of Event (classroom, office, stairs, etc.)	Building ----- Floor & Room
What happened? (Description of event and how it occurred)	
Were you injured? (Description of injury, including parts of the body)	
What factors contributed to the event?	
How could the event have been avoided	
Was First Aid administered? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, by whom?	
Signature of Injured Party/ Complainant	Date
<i>If form completed by someone other than the injured party, please fill out the following lines</i>	
Form Completed by:	Telephone Number
Signature	Date

APPENDIX 4
Incident / Accident Report Form

STATE OF QATAR
QATAR UNIVERSITY



INCIDENT / ACCIDENT REPORT FORM

Section C: General Information	
Supervisor's Last Name	Supervisor's First Name
Department	Position
Telephone No.	Email
If there was a delay in reporting this event, list reason (s)	
Material Damage YES <input type="checkbox"/> NO <input type="checkbox"/> Approximate Value:	
Section D: Preventive Measure	
Cause of event – Root Causes (e.g. unsafe equipment, lack of training, etc)	
What corrective actions are being taken to prevent recurrence?	
Frequency of the task or activity that led to the event: <input type="checkbox"/> Often (daily or weekly) <input type="checkbox"/> Occasionally (monthly) <input type="checkbox"/> rare (1-4 times per year)	
Has a risk assessment been carried out for the process/ activity	YES <input type="checkbox"/> NO <input type="checkbox"/>
Have person (s) involved receive training or instruction in the work or activity being carried out?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Was there any supervisor of the work being carried out?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Supervisor's Comment (Additional information on event)	
If injury occurred, please check one <input type="checkbox"/> No First Aid administered, returned to work <input type="checkbox"/> Saw a physician, returned to light duty	

QATAR UNIVERSITY

Office and Classroom Safety

<input type="checkbox"/> First Aid administered, returned to work	<input type="checkbox"/> Saw a physican, time loss
<input type="checkbox"/> Saw a physician, return to work	<input type="checkbox"/> Refused medical treatment

Safety Committee Use only

Reviewed by:	Date
--------------	------

Distribution
<input type="checkbox"/> Department / College Head <input type="checkbox"/> HR <input type="checkbox"/> Chair Safety Committee

Follow up
<input type="checkbox"/> Supervisor <input type="checkbox"/> Dept./ College Head <input type="checkbox"/> Chair Safety Committee
<input type="checkbox"/> Others _____