



FINGAL COUNTY COUNCIL

Public Event

Accident / Incident Report Form

Name:			
Contact number:			
Person completing this form:			
Position:			
Date:		Time:	



EXACT LOCATION OF ACCIDENT / INCIDENT:

(Give details of the location including underfoot conditions, lighting, heating, noise etc.)

DESCRIBE CIRCUMSTANCES OF ACCIDENT / INCIDENT:

DETAILS OF INJURIES / PROPERTY DAMAGE:

Witness Name:	
Contact number:	
Witnesses account of the accident / incident:	

Was medical treatment required:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Declined <input type="checkbox"/>
Was medical administered:			
If so, by whom	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Declined <input type="checkbox"/>
Further medical attention required:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Declined <input type="checkbox"/>

Was accident / incident notifiable:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
An Garda Siochana	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Health & Safety Authority	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Insurance company	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>

STEPS TAKEN TO PREVENT RE-OCCURRENCE:

Signed:	
Date:	