



## Accident / Incident Report Form

Date: \_\_\_\_\_ | Inspector: \_\_\_\_\_ | Doc #: \_\_\_\_\_

Project / Site Name	
Address / Location	
Date & Time of Incident	
Reported By (Name / Role)	
Supervisor / Manager	
Weather / Site Conditions	
Type of Incident	<input type="checkbox"/> Injury to Person <input type="checkbox"/> Near Miss <input type="checkbox"/> Property Damage <input type="checkbox"/> Environmental Spill <input type="checkbox"/> Other _____

### PERSONS INVOLVED

NAME	ROLE / JOB TITLE	CONTACT	INJURY / EFFECT	HOSPITALIZED?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No



## Description of Incident

Provide a detailed account of what happened, including sequence of events and contributing factors.

## Immediate Actions Taken

Describe steps taken immediately after the incident to prevent further harm or damage.

## WITNESSES

NAME	CONTACT	STATEMENT



## Root Cause Analysis

Identify the underlying cause(s) of the incident.

## CORRECTIVE AND PREVENTIVE ACTIONS

ACTION REQUIRED	RESPONSIBLE PERSON	TARGET DATE	STATUS
			<input type="checkbox"/> Pending <input type="checkbox"/> In Progress <input type="checkbox"/> Completed
			<input type="checkbox"/> Pending <input type="checkbox"/> In Progress <input type="checkbox"/> Completed
			<input type="checkbox"/> Pending <input type="checkbox"/> In Progress <input type="checkbox"/> Completed

## Severity Assessment

Severity

Minor  
  Moderate  
  Major  
  Critical



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### Sign-Off

Reported By Signature

\_\_\_\_\_

Date:

Supervisor / Manager Signature

\_\_\_\_\_

Date:

