WASTESERV
CREATING RESOURCES FROM WASTE

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Incident Report Form

This form should be completed and forwarded to the following email: incidents.ws@wasteservmalta.com, as soon as possible after the incident. The original copy should be submitted to the Health & Safety Department. This form should be completed by the Head of Shift, Supervisor, and/or H&S Leader in conjunction with the person/s involved in the incident (wherever possible).

Incident Number
(for office purposes only):

Section 1 – Incident Information

Date of Incident: _____ OBU: _____

Time of Incident: _____ Place of Incident: _____

Nature of Incident: Near Miss [ ] Injury [ ] Spill [ ] Fire [ ] Damaged Asset [ ]

Description of Incident:

Was any equipment involved in the incident? [Yes / No] If Yes, please specify which equipment:

Provide details of personnel involved in the incident.

NAME & SURNAME	*ID CARD NO*	*JOB TITLE*	*SHIFT TYPE*	*OBU*	*SIGNATURE **

Provide details of any witnesses of the incident.

NAME & SURNAME	*ID CARD NO*	*JOB TITLE*	*SHIFT TYPE*	*OBU*	*SIGNATURE **

*** By signing this form, you confirm that you understand the information included in the form and that the information is correct.**

Acknowledged by:

Head of OBU	**Signature**	**Date**

Section 2 – Injury Details

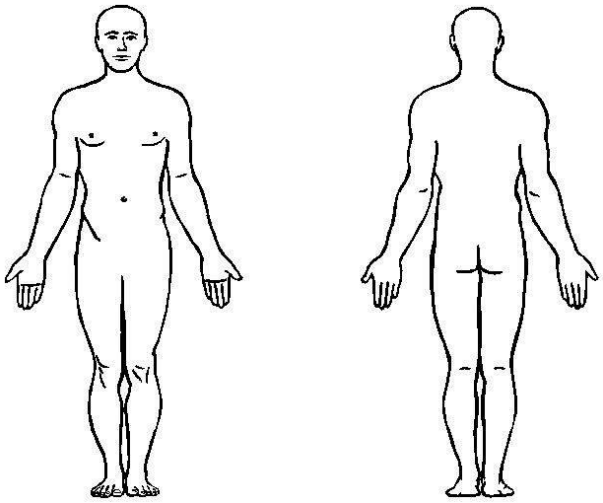
Note: In case of injury please fill in this section. In case of more than one injured employee, this page is to be filled-in for each employee injured.

Employee Injured: _____

Specify type of injury:

	(Tick as applicable)		*(Tick as applicable)*
Superficial injury	[ ]	Poisoning and infections	[ ]
Fracture of bones	[ ]	Drowning and shortness of breath	[ ]
Dislocations and disjoints	[ ]	Noise effects	[ ]
Amputation of body parts	[ ]	External temperature, light and radiation effects	[ ]
Concussion and internal injury	[ ]	Shock	[ ]
Burns, scalds, and skin inflammation	[ ]	Multiple injury	[ ]

Which body parts were injured?



Was first aid administered to casualty?	[Yes / No]
Name of First Aider	
Code of First Aid Box	
Specify type of First Aid given and any First Aid equipment used	

Was an ambulance called?	[Yes / No]
Was casualty taken to clinic / health centre?	[Yes / No]
Was casualty taken to hospital?	[Yes / No]
Did employee return to work following the incident?	[Yes / No]

Head of OBU Signature	**Date**

Section 3 – Spill Incident Details

Note: In case of spill please fill in this section.

Description/ Name of material spilled: _____

Quantity of material spilled: _____

Has the material reached any of the below?		*Quantities (where applicable)*
Sewer	[Yes / No]	_____
Soil	[Yes / No]	_____
Road	[Yes / No]	_____
Sea	[Yes / No]	_____

Name of ERT member: _____

Code of Spill Kit used: _____

Quantity of spill kit material used:

PPE	_____
Booms	_____
Pillows	_____
Mats	_____
Disposal Bags	_____
Other Cleaning Agents	_____

Head of OBU Signature	**Date**

(For office purposes only)

Was the incident reported to ERA? [Yes / Not necessary]

Date reported: _____ Reported by: _____

Manager – Compliance	**Date**

Section 4 – Fire Incident Details

Note: In case of fire please fill in this section.

Duration of fire: _____

Location of fire: _____

Fuel (if known): _____

Potential source of ignition (if known): _____

List any damages noted on site.

[1] _____ [5] _____

[2] _____ [6] _____

[3] _____ [7] _____

[4] _____ [8] _____

Was the premises evacuated?	[Yes / No]
Did everyone report to the Assembly Point?	[Yes / No]
Was a Roll Call carried out?	[Yes / No]
Was the Civil Protection Department summoned?	[Yes / No]

Fire extinguishing media used:

Fire Extinguishers	[ ]	If yes, specify the code/s of the fire extinguisher/s.	_____
Fire Hose Reel	[ ]	If yes, specify the code/s of the fire hydrant/s.	_____
Fire Hydrants	[ ]		
Fire Cannons	[ ]		
Fire Sprinklers	[ ]		
Others	[ ]		

Head of OBU Signature	**Date**

(For office purposes only)

Was the incident reported to ERA? [Yes / Not necessary]

Date reported: _____ Reported by: _____

Manager – Compliance	**Date**

Section 5 – Damaged Asset Details

Note: In case of damaged asset/s please fill in this section.

WS Asset Number: _____

Type of Asset: _____

Identification Code (where applicable): _____

Is the asset a vehicle or mobile equipment? ☐Yes ☐No

Insurance claim required? ☐Yes ☐No

Details of damaged caused:

[1] _____ [5] _____

[2] _____ [6] _____

[3] _____ [7] _____

[4] _____ [8] _____

Warden Report Number (where applicable): _____

If damage to asset was done by a third party / hauler, please populate the fields below:

Vehicle Number: _____

Name & Surname: _____ ID No.: _____

Company Name: _____

Signature: _____

Head of OBU Signature	**Date**