



Notification of Accident / Injury at Squash Club

Name of Injured Person		Address	
Home		Mobile	
Date		Time	

Location	
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What type of Accident ? [Please tick appropriate box]

Contact with electricity or discharge	<input type="checkbox"/>	Contact with moving machinery	<input type="checkbox"/>
Chemical / Substance injury	<input type="checkbox"/>	Drowned or asphyxiated	<input type="checkbox"/>
Exposed to fire	<input type="checkbox"/>	Fell from a height	<input type="checkbox"/>
Hit by moving, falling or flying object	<input type="checkbox"/>	Hit by moving vehicle on car park	<input type="checkbox"/>
Hit by something fixed or stationary	<input type="checkbox"/>	Injured when handling / lifting / carrying	<input type="checkbox"/>
Physically assaulted by a person	<input type="checkbox"/>	Slipped, tripped or fell on same level	<input type="checkbox"/>
Trapped by something collapsing	<input type="checkbox"/>	Disease related	<input type="checkbox"/>
Any other kind of accident	<input type="checkbox"/>	(please state) <input type="text"/>	

Which category of Accident ?

Superficial	<input type="checkbox"/>	Minor	<input type="checkbox"/>
Taken off site for treatment	<input type="checkbox"/>	Serious	<input type="checkbox"/>
Fatality	<input type="checkbox"/>	Disease	<input type="checkbox"/>
Other	<input type="checkbox"/>	(please state) <input type="text"/>	

Part(s) of Body involved ?

Arm	<input type="checkbox"/>	Back	<input type="checkbox"/>
Eye	<input type="checkbox"/>	Foot	<input type="checkbox"/>
Hand	<input type="checkbox"/>	Head	<input type="checkbox"/>
Leg	<input type="checkbox"/>	Neck	<input type="checkbox"/>
Shoulder	<input type="checkbox"/>	Torso	<input type="checkbox"/>
Other	<input type="checkbox"/>	(please state)	<input type="text"/>

What actually happened ? (continue on separate sheet if necessary)

Were there any witnesses ? (If so please give their contact details)

Name	Contact details
1.	
2.	

Could anything be (or has anything been) done to prevent such an incident re-occurring ?

Did the injured person attend hospital ?

Yes No

If so, which hospital ?

Was he /she detained and, if so, for how long ?

Signature and Date: