

Ill Health (work related) Reporting Form

Work Related Ill Health is classified as an illness or disease caused or made worse by the working environment. This form should be used where an illness or disease is suffered during work time (whether work related or not) or if exposed to an agent which has the potential to cause illness/disease later. Communicable disease is reported via employees sickness record, with exception to where COVID-19 has been contracted in connection with the work activities, this needs to be reported on the Near Miss form.

Incident Date	<input type="text"/>	Incident Time	<input type="text"/>
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Person reporting this incident

Your full name:	<input type="text"/>
Your job title:	<input type="text"/>
Please provide the name of your team:	<input type="text"/>
Your contact number:	<input type="text"/>
Your e-mail address:	<input type="text"/>
Date incident was reported to you:	<input type="text"/>
Time incident was reported to you:	<input type="text"/>

About the person affected by the incident

Full name of affected person:

Is the affected person an employee?

☐ Yes ☐ No

Status of the Non-Employee:

You have selected non-employment status as 'other', please provide the status below:

Employer's name (if available):

Affected person's telephone number (if available):

Affected persons e-mail (if available):

Affected persons Job Role (if relevant and available):

Do you know the address of the affected person?

☐ Yes ☐ No

Address Line 1

Address Line 2

Address Line 3

Town/ City:

County

Postcode:

Age of the injured party:

Gender of the injured party:

About the incident

Select the location of the incident

Other location:

Describe where on the premises or outside space this happened?

Main contributory factor involved in the incident:

Please provide other cause not listed above:

What work/ activity was being undertaken at the time of the incident?

Incident Type

Describe how the person became ill in as much detail as possible:

What was the apparent cause of the ill-health?

Was there any property, equipment or vehicle damaged as a result of this incident?

What damage was caused?

Please describe how the damage was caused:

Illness sustained

What illness was sustained?

Other not known - please explain why it is not known:

Other known illness - Please describe:

Please describe the illness sustained:

Did the person affected die as a result of exposure to a substance at work?

☐ Yes

☐ No

Was first aid treatment received?

☐ Yes

☐ No

☐ Not applicable

Who gave the first aid treatment?

What treatment was given:

Why was first aid treatment not required:

Was treatment by a medical professional required? ☐ Yes ☐ No ☐ Not applicable

Was the person absent from work following the ill health? ☐ Yes ☐ No

The first full day the affected person was away from work

Has the person returned to work? ☐ Yes ☐ No ☐ Not applicable

Date person returned to work:

In what capacity did the person return to work

If relevant, please attach any relevant documentation relating to the ill health:

Were immediate actions needed to prevent a re-occurrence? ☐ Yes ☐ No

What actions were taken to stop a re-occurrence of this incident:

Has the person affected received a diagnosis of any of the following

-----> ☐ Yes ☐ No

Please select the city, borough or district did this occurred in:

Main activity carried out at the incident location:

Work being undertaken at the time of the incident

Witness to the incident

Was there a witness to the incident? ☐ Yes ☐ No

Name of witness:

Job title of witness (if applicable)

Telephone number of witness (where available)

E-mail address of witness (where available)

Address of witness (where available):

What the person witnessed:

Has a witness statement been provided? ☐ Yes ☐ No

Please attach statement:

Was there additional witnesses to this incident? ☐ Yes ☐ No

Save and Submit Declaration