



Date of Notification

**Part I : Particulars of reporting unit**

Name of facility

Unit / Department / Ward

**Part II : Particulars of patient**

Date seen/treated/admitted

Medical certificate (MC) given  No  
 Yes

Duration of MC  days

**Part III : Classification of accident**  
 (Tick  more than one if relevant)

1. Nature of injury

- |  |   |
|--|---|
| <input type="checkbox"/> Abrasions                   | <input type="checkbox"/> Effect of radiation          |
| <input type="checkbox"/> Amputation                  | <input type="checkbox"/> Fracture                     |
| <input type="checkbox"/> Asphyxia                    | <input type="checkbox"/> Drown                        |
| <input type="checkbox"/> Burns (heat)                | <input type="checkbox"/> Laceration                   |
| <input type="checkbox"/> Burns (chemical)            | <input type="checkbox"/> Sharp injuries               |
| <input type="checkbox"/> Bruises and contusions      | <input type="checkbox"/> Sprain & strain              |
| <input type="checkbox"/> Concussions                 | <input type="checkbox"/> Internal injuries            |
| <input type="checkbox"/> Cuts                        | <input type="checkbox"/> Splash of blood/body fluid   |
| <input type="checkbox"/> Dislocation                 | <input type="checkbox"/> Splash of chemicals          |
| <input type="checkbox"/> Effect of electric currents | <input type="checkbox"/> Other (please specify) _____ |

2. Part of Body Injured For R/L : Please circle

- | Head and Neck                     | Upper Limbs                                   | Torso                            | Lower Limbs                        |
|-----------------------------------|---|----------------------------------|------------------------------------|
| <input type="checkbox"/> Scalp    | <input type="checkbox"/> Upper arms R/L       | <input type="checkbox"/> Back    | <input type="checkbox"/> Hip R/L   |
| <input type="checkbox"/> Skull    | <input type="checkbox"/> Elbow R/L            | <input type="checkbox"/> Chest   | <input type="checkbox"/> Thigh R/L |
| <input type="checkbox"/> Eyes R/L | <input type="checkbox"/> Forearm R/L          | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Leg R/L   |
| <input type="checkbox"/> Ears R/L | <input type="checkbox"/> Wrist R/L            | <input type="checkbox"/> Pelvis  | <input type="checkbox"/> Knee R/L  |
| <input type="checkbox"/> Nose     | <input type="checkbox"/> Hand R/L             | <input type="checkbox"/> Groin   | <input type="checkbox"/> Ankle R/L |
| <input type="checkbox"/> Mouth    | <input type="checkbox"/> Palm R/L             |                                  | <input type="checkbox"/> Feet R/L  |
| <input type="checkbox"/> Teeth    | <input type="checkbox"/> Fingers R/L          |                                  | <input type="checkbox"/> Toes R/L  |
| <input type="checkbox"/> Face     | <input type="checkbox"/> Other specify: _____ |                                  |                                    |
| <input type="checkbox"/> Neck     |   |                                  |                                    |

3. Mechanism of accident

- |  |   |
|--|---|
| <input type="checkbox"/> Struck against object                                     | <input type="checkbox"/> Exposure to/or contact with harmful substances/radiation |
| <input type="checkbox"/> Struck by sliding, falling, flying or other moving object | <input type="checkbox"/> Exposure to/or contact with electric currents            |
| <input type="checkbox"/> motor vehicle accident                                    | <input type="checkbox"/> Exposure to explosion                                    |
| <input type="checkbox"/> Caught in/or between object                               | <input type="checkbox"/> Drowning   |
| <input type="checkbox"/> Fall or slip on same level                                | <input type="checkbox"/> Crush by moving/sliding object                           |
| <input type="checkbox"/> Fall from height  | <input type="checkbox"/> Needle stick/Needle prick                                |
| <input type="checkbox"/> Injured while handling, lifting or carrying               | <input type="checkbox"/> Physical assault   |
| <input type="checkbox"/> Contact with extreme temperature                          |   |
| <input type="checkbox"/> Others (please specify): _____                            |   |

**WEHU - A2 (cont'd)**

4. Agent involved in accident

- Machine/Electrical equipment
- Lifting equipment
- Transport equipment/Vehicle
- Needles
- Medical/Surgical/Dental instruments (other than needles)
- Lab instruments
- Pressure Vessels
- Blood/Body fluids
- Chemicals/Gases
- Floors/Levels
- Ladders
- Stairs/steps
- Others (please specify) \_\_\_\_\_

5. Existing control measure at workplace

- Engineering Control
- Standard Operating Procedure (SOP)
- Training/Education/Work Schedule/Rotation
- Personal Protective Equipment (PPE)
- Other (please specify) \_\_\_\_\_