GOVERNMENT OF BERMUDA
Ministry of Health
Department of Health

DANGEROUS OCCURRENCES REPORT FORM – FORM OSH 06

OCCUPATIONAL SAFETY AND HEALTH ACT 1982
OCCUPATIONAL SAFETY AND HEALTH REGULATIONS 2009

SECTION 1 - EMPLOYER INFORMATION					
Name of Company/Agency/Government Department:					
Employer's Address and Postal Code:					
Tel No:		Fax No:		E-mail:	
Name of Person in control of place of employment:					
Tel No:		Fax No:		E-mail:	

SECTION 2 – EMPLOYEE INFORMATION					
Full Name of Employee:					
Email and contact phone #:					
Occupation/Job Title:		Age:		Male ☐	Female ☐
Office Employee ☐	Non-Office Employee ☐	Sub-contractor ☐			

SECTION 3 – INCIDENT SITE INFORMATION				
Date of Incident	D	M	Y	Time
Site of Incident (including address):				
Work Activity at time of Incident:				
Weather conditions (if a contributing factor):				

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Name(s) and contact phone # and email addresses of witness(es):

SECTION 4 – NATURE OF INCIDENT

Near miss ☐ Minor Injury ☐ resulting in: Serious injury ☐ Or, Death ☐	Unfit for work ☐ #Hours of Lost time)_____	Loss of body part ☐ Permanent impairment of a body function ☐	Occupational Exposure/illness ☐

SECTION 5 - PART OF BODY INJURED AND CAUSE OF INJURY

Eyes (L) ☐ (R) ☐	☐	Ears (L) ☐ (R) ☐	☐	Face	☐	Neck	☐	Head	☐
Arm (L) ☐ (R) ☐	☐	Wrist (L) ☐ (R) ☐	☐	Hand (L) ☐ (R) ☐	☐	Finger (s)	☐	Upper body	☐
Leg (L) ☐ (R) ☐	☐	Ankle (L) ☐ (R) ☐	☐	Foot (L) ☐ (R) ☐	☐	Toe(s)	☐	Lower body	☐
Back (lower) ☐	☐	Lung (L) ☐ (R) ☐	☐	Internal organs	☐	Other ☐			

FIRST AID TREATMENT ONLY: YES ☐ NO ☐ OR HOSPITAL TREATMENT REQUIRED YES ☐ NO ☐

DESCRIBE INJURY, EXPOSURE, ILLNESS, ETC.:

SECTION 6 - INVESTIGATION FINDINGS

(A) THE SEQUENCE OF EVENTS LEADING UP TO THE INCIDENT:

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(B) INCIDENTS INVESTIGATION: *(please tick the appropriate boxes to indicate the contributing factors)*

	Work Materials		Work Procedures		Environment
	Poorly labeled		Inadequately documented		Inadequate Housekeeping
	Inadequately handled		Procedure non-compliance		Inadequate Lighting
	Inadequately stored		Inadequate safety considerations		Inadequate Ventilation
	Improper PPE or lack of use		Improper technique		Poor workplace design
	Machines and Tools		**Manpower**		**Management Control**
	Inadequately inspected		Inadequately trained		Inadequate supervision
	Insufficiently guarded		Physical limitation		Inadequate safety planning
	Failed emergency mechanism		Mental limitation		Non-response to identified issues
	Unauthorized use		Employee error		Ineffective lines of communication
	Defective machine and/or tool		Insufficient knowledge of job		
Other: *(please specify)*					

(c) CAUSES AND CIRCUMSTANCES OF INCIDENT: Please attach photos, witness statements, site plan, etc.

(D) CORRECTIVE ACTION PLAN:

Name of person appointed to conduct the investigation:	Name of Safety and Health Committee Chair :	Date: D___M___Y_____
Signature of person appointed to conduct the investigation:	Signature of Safety and Health Committee Chair:	Date: D___M___Y_____

SECTION 7- FOR SAFETY AND HEALTH OFFICE USE ONLY

Report forwarded to OSH Office	YES ☐	Date: D_____ M_____ Y_____

Follow-up Action	**YES**	☐	**NO**	☐	