



**What was the Cause and Circumstance of accident( please give as much details as possible:**

**Please provide details of any injury or damage to property** (please give as much details as possible **and** if you have suffered an injury please also complete the attached medical release mandate)

**Details of Hospital (if attended):**

Dalriada House, Lochgilphead, Argyll, PA31 8ST • Tel: 01546 604524 • Fax: 01546 604831 • Web: [www.acha.co.uk](http://www.acha.co.uk)

Argyll Community Housing Association Limited. Registered Office at: 63-65 Chalmers Street, Ardrishaig, PA30 8DX  
Registered under the Industrial and Provident Societies Act 1965, Reg. No. 2661R(S)

**Witnesses – please provide names/addresses or contact details for any witnesses:**

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<b>Signature:</b>		<b>Date:</b>	
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## Mandate

Full Name		
Address		
Telephone Number (daytime)		
Date of Incident/Accident		
Date of Birth		
National Insurance Number		
Name and Address of Doctor		

I consent to release of any relevant records, including medical or occupational health referrals, relevant to the above accident /incident being released to Argyll Community Housing Association and/or its insurers. Please return this form to Argyll Community Housing Association, Finance & IT, Dalriada House, Lochnell Street, Lochgilphead, PA31 8ST . This information will be used for claims investigation purposes only.

Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Date \_\_\_\_\_