Incident Report Form

Status: ❑ Franchise Partners ❑ Contractor ❑ Other

Outcome: ❑ Near miss ❑ Injury

1. DETAILS OF INJURED PERSON

Name: _____ Phone: (H)_____ (W)_____

Address:_____ Sex: ❑ M ❑ F

_____ Date of birth:_____

_____ Position: _____

Experience in the job:_____ (years/months)

Start time:_____ ❑ am ❑ pm

Work arrangement: ❑ Casual ❑ Full-time ❑ Part-time ❑ Other

2. DETAILS OF INCIDENT

Date: _____ Time: _____

Location: _____

Describe what happened and how: _____

_____

_____

3. DETAILS OF WITNESSES

Name: _____ Phone: (H)_____ (W) _____

Address: _____

_____

_____

4. DETAILS OF INJURY

Nature of injury (e.g., burn, cut, sprain) _____

Cause of injury (e.g., fall, grabbed by person)_____

Location on body (e.g., back, left forearm) _____

Agency (e.g., lounge chair, another person, hot water)_____

5. TREATMENT ADMINISTERED

First Aid given ❑ Yes ❑ No

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First Aid given ❑ Yes ❑ No

First Aider name: _____

Treatment: _____

Referred to: _____

6. DID THE INJURED PERSON STOP WORK?

❑ Yes ❑ No If yes, state date: _____ Time: _____

Outcome:

❑ Treated by doctor ❑ Hospitalised ❑ Workers' compensation claim

❑ Returned to normal work ❑ Alternative duties ❑ Rehabilitation

7. INCIDENT INVESTIGATION (comments to include causal factors):

_____

_____

_____

_____

8. RISK ASSESSMENT

Likelihood of recurrence: _____

Severity of outcome: _____

Level of risk: _____

9. ACTIONS TO PREVENT RECURRENCE

Action	By whom	By when	Date completed

10. ACTIONS COMPLETED

Signed (Manager): _____ Title: _____

Date: _____

❑ Feedback to person involved Date: _____

11. REVIEW COMMENTS

OHS committee / staff meeting: _____

Reviewed by site Manager (signed): _____ Date: _____

Reviewed by Health & Safety Rep.(signed): _____ Date: _____