Please print clearly and tick the correct box

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Status** |  | Employee | |  | Contractor | |  | Other |
| **Outcome** | * Near miss | | | * Injury | | | * Other | |
| **1. Details of injured person** | | | | | | | | |
| **Name** |  | | | Phone | | |  | |
| **Address** |  | | | | | | | |
| **Gender** |  | | | Date of Birth | | |  | |
| **Position** |  | | | | | | | |
| **2. Details of incident** | | | | | | | | |
| **Date** |  | | | Time | | |  | |
| **Location** |  | | | | | | | |
| **Describe what happened and how** |  | | | | | | | |
| **Who reported incident** | Name: | |  | | | Date/Time: | |  |
| **3. Details of witnesses** | | | | | | | | |
| **Name** |  | | | Phone | | |  | |
| **Address** |  | | | | | | | |
| **4. Details of injury** | | | | | | | | |
| **Name 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 |
| **First Aider Name** |  | | | | | | | |
| **Treatment** |  | | | | | | | |
| **Referred to** |  | | | | | | | |

|  |
| --- |
| **Section 6-9 Must be completed by employer** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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 | | * Rehabilitation | * Alternative duties | | |
| **7. Incident investigation (comments to include causal factors)** | | | | | |
|  | | | | | |
| **8. Risk Assessment** | | | | | |
| **Likelihood of reoccurrence** | |  | | | |
| **Severity of outcome** | |  | | | |
| **Level of risk** | |  | | | |
| **9. Actions to prevent recurrence** | | | | | |
| **Action** | | **By Whom** | **By Date** | | **Date Completed** |
|  | |  |  | |  |
| **10. Actions Completed** | | | | | |
| Signed (Manager) | |  | Date | |  |
| * Feedback to person involved | | | Date | |  |
| **11. Review Comments** | | | | | |
| OHS Committee/staff meeting: | |  | | | |
| Reviewed by Manager (signed) | |  | | Date |  |
| Reviewed by Health and Safety Rep (signed) | |  | | Date |  |