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 |  |