INCIDENT REPORT FORM

PERSONAL DETAILS	
Status: Labour Hire Worker	Position:
Full Name:	DOB:

INCIDENT DETAILS *(completed by the person involved)*	
Date of Incident:	Time of Incident:
Location of Incident:	
Report to - Name:	Position:
Date reported:	Time:
Description of incident:	

INJURY DETAILS		
Part of Body: *(be specific)*		
Type of Injury:		
How it happen:		

TREATMENT DETAILS		
Not required ☐	First Aid ☐	Ambulance ☐
Refused Treatment ☐	Own Doctor ☐	Hospital Admission ☐
Other, specify:		
First Aid Report and Other Information:		
Immediate Outcome: Return to Work ☐	Hospitalised ☐	Other
Date ceased work:	Date resumed work:	
Employee Signature:	Date:	

NAME OF WITNESSES TO THE INCIDENT:	
Witness 1 Name:	Contact Details:
Witness 2 Name:	Contact Details:
Witness 3 Name:	Contact Details:

WORK HEALTH AND SAFETY MANAGER *(to complete)*

DETAILS OF OTHER PERSONS INVOLVED		
Did the incident involve any other person?	Yes ☐	No ☐
(if yes, provide their name and contact details)		

DETAILS OF ANY DAMAHE		
Did any damage to property occur?	Yes ☐	No ☐
(if yes, provide details of the damage)		

INCIDENT SECURITY		
Has the area of the incident been secured to prevent unauthorised access?	Yes ☐	No ☐
Are Immediate Corrective Actions required to render the area safe or to eliminate or minimise an immediate risk?	Yes ☐	No ☐

IMMEDIATE CORRECTIVE ACTION REQUIRED *(to render safe)*		
Describe what needs to be done	**Who is responsible?**	**Date for completion**

AUTHORISATION OF IMMEDIATE CORRECTIVE ACTIONS		
Name	**Signature**	**Date**

OTHER DETAILS		
Were the Police or other emergency services involved?	Yes ☐	No ☐
(If yes, provide details of the offices attending)		
Does the incident require notification to the workplace health and safety regulator? *(eg. Return to Work SA)*	Yes ☐	No ☐
Was the workplace health and safety regulator informed?	Yes ☐	No ☐
Is this a worker's compensation related incident?		
Was the worker's compensation insurer notify?	Yes ☐	No ☐
Is an internal incident investigation required?	Yes ☐	No ☐

Consideration for additional corrective action:
Change to inductions, Change to ongoing training, Change to work procedure, Equipment maintenances, Job re-design, Site clean-up, Risk assessment review, Risk control review, Other Prevention actions

ACCIDENT INVESTIGATION REPORT *This report to be attached to the injury report for processing by TEMP FILL-INS*

EMPLOYEE DETAILS	
Name:	Nature of injury:
INVESTIGATION	
Description of Incident:	Primary Causes:
Recommendations to Avoid Recurrence:	Contributing Causes:
Is further investigation required?	YES ☐ NO ☐
Employee Signature:	Date:

ACCIDENT INVESTIGATION REPORT – CHECKLIST

The Incident			The Injury		
YES	NO	***Did the incident involve:***	YES	NO	***Did the incident result in:***
		Failure of personal protective equipment (PPE)?			First Aid treatment only?
		Needle stick/Sharps?			Immediate medical treatment?
		Steam?			Loss of consciousness?
		Hot surfaces?			Fatality?
		Evacuation procedure?			Amputation?
		Contractors on site?			Bone fracture?
		Injury?			Eye injury?
		Lifting?			Electric shock?
		Electrical?			Electrical burns?
		Explosion?			Burns?
		Explosive?			Decompression sickness?
		Fire?			Hospitalisation for 24 hours or more?
		Escape of flammable liquid?			Three or more days' absence from work?
		Escape of gas?			
		Escape of other substance?			
		Collapse building, structure?			
		Pipe line?			
		Failure of equipment?			

The Immediate cause of injury		
YES	NO	***Was the person injured by:***
		Needle stick/sharps injury?
		Contact with a harmful substance?
		Exposure to a harmful substance?
		Contact with moving parts or materials on a machine?
		Being struck by moving/falling object?
		Being struck by a moving vehicle?
		Striking against something not moving?
		Handling, lifting or carrying a load?
		Slipping, Tripping or falling on the same level?
		Falling from a height?
		Being trapped by something collapsing or overturning?
		Exposure to fire?
		Contact with a hot surface?
		Contact with electricity or electrical discharge?