Incident Report Form

The XYZ Company is committed to providing and maintaining a safe and healthy workplace environment, and ensuring all our work practices are conducted safely.

All injuries/illnesses and incidents sustained at work must be reported immediately so that appropriate treatment can be given, the causes investigated, and control measures implemented as soon as possible to prevent a similar accident from occurring in the future. Near misses that did not cause injury must also be reported.

Occupational Health and Safety legislation in all states require employers to record all injuries sustained at work, in a Register of Incidents/Accidents.

Instructions

- An Incident Report Form must be completed for all employee and contractor Incidents/Accidents, regardless of how insignificant the injury may appear to be.
- This is **NOT** a Workers' Compensation Claim Form.
- The Incident Report Form is to be initiated by the attending First Aider, who should complete all Sections 1 – 6 and sign the form where appropriate as soon as possible after the Incident/Accident.
- The First Aid Attendant should immediately forward the completed form to the relevant line manager.
- The form should be reviewed and, if appropriate, an incident investigation commenced within 24 hours and Incident Investigation Report Form completed.
- The original copy should be held centrally and filed alphabetically in the Register of Incidents/Accidents. The form must be kept for a minimum of seven (7) years.
- If the injury results in a Workers' Compensation Claim, a copy of the Incident/Accident Report should be attached to the Workers' compensation Claim Form.
- If the incident is significant or serious, the relevant State OH&S Authority must be notified (refer to Notifiable Incidents in the Incident Reporting and Investigation section of the OH&S Procedure Manual). The CML OH&S department may also need to be notified by fax (refer to 'Critical Events' in the Incident Reporting and Investigation section of the OH&S procedure Manual).

NOTE: Only when injury results in medical expenses or lost time should the employee be advised to complete a Workers' Compensation Claim Form (available through Administration).

- All Incident Report Forms must be reviewed by ???? (Include name of person responsible).

INCIDENT REPORT FORM

☐ Injury/Illness ☐ Property Damage ☐ Near Miss (*dangerous occurrence, no injury or property damage*)

Location: (DC) _____ Ref No: _____

Date Received by OHS Coordinator/HR Department: _____

Section 1. – Personal/Employment Details

Full Name: _____ Employee No: _____

Address: _____ Postcode: _____

Date of Birth: _____ Gender M / F

Occupation: _____ Time in this Job: _____

Department: _____ Supervisor/Line Manager: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Casual ☐ Contractor/non-Employee

If not an employee of company XYZ, state name of employer: _____

Section 2. – Occurrence of the Incident

Date of Incident: _____ Time of Incident: _____ Date Reported: _____

Work Activity being performed at the time of the Incident: _____

Exact Location of Incident: _____

Describe in full, the circumstances of the incident (*provide attachment if needed*) _____

_____

_____

_____

Names and contact details of witnesses: _____

_____

Section 3. – Type of Injury

☐ Strains/Sprains	☐ Amputation	☐ Animal/insect bite	☐ Puncture wound
☐ Lacerations/Abrasions	☐ Hearing Loss	☐ Hernia	☐ Soft tissue injury
☐ Contusion (Bruise)	☐ Foreign body	☐ Welding flash	☐ Heat stress/Exhaustion
☐ Burns - heat	☐ Dermatitis (Skin rash)	☐ Dental	☐ Pain/Tenderness
☐ - chemical	☐ Respiratory irritation	☐ Twist	☐ Disease
☐ - other	☐ Toxic reaction	☐ Whip lash	☐ Swelling ☐ Multiple
☐ Fracture/Dislocation	☐ Internal	☐ Crush injury	☐ Other (Specify)

Part of Body Injured: ☐ Left ☐ Right ☐ Multiple

☐ Chest	☐ Arm upper	☐ Head/Face	☐ Back upper	☐ Foot	☐ Finger (Specify) _____
☐ Abdomen	☐ Arm lower	☐ Scalp	☐ Back middle	☐ Ankle	☐ Toe (Specify) _____
☐ Hip	☐ Elbow	☐ Nose	☐ Back lower	☐ Other (Specify)	_____
☐ Genitals	☐ Wrist	☐ Ears	☐ Leg upper	☐	_____
☐ Groin	☐ Hand	☐ Eyes	☐ Leg lower	☐	_____
☐ Circulatory	☐ Shoulder	☐ Neck	☐ Knee	☐	_____

Is it a recurring injury? **Yes** ☐ **No** ☐

Section 4. – Property Damage

Description of damage : _____

_____

Section 5. – Treatment

Was any Treatment Required? ☐ Nil ☐ First Aid ☐ Referred to Doctor ☐ Sent to Hospital

Ambulance called Returned to Work

First Aid Attendant: _____

First Aid Treatment Given: _____

_____

Section 6. – Work Status following injury

☐ Return to normal duties ☐ Left work – Home/Hospital/Doctor ☐ Alternative Duties

Is it likely that person may miss one complete shift? ☐ Yes ☐ No

ALTERNATIVE DUTIES

Hours: _____ ☐ _____ ☐ _____

Rehabilitation Required: **Yes** **No**

ALTERNATIVE DUTIES

Type of duties given: _____

_____

A copy of this report has been provided to the Employee Yes ☐ No ☐

Supervisor/Line Manager Signature: _____ **Employee Signature:** _____

Incident Investigation Required? (*refer to guidelines in OHS Procedure Manual*) Yes ☐ No ☐

If yes, Supervisor/Line Manager responsible _____

Notification of Incident Required? Yes ☐ No ☐ Date Achieved: _____