

# Incident Injury Report Form

Please print clearly and tick the correct boxes.

Status:       Employee       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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 2. DETAILS OF WITNESSES

Name: \_\_\_\_\_ Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Address: \_\_\_\_\_

## 4. DETAILS OF INJURY

Nature of injury (eg burn, cut, sprain) \_\_\_\_\_

Cause of injury (eg fall, grabbed by person) \_\_\_\_\_

Location on body (eg back, left forearm) \_\_\_\_\_

Agency (eg lounge chair, another person, hot water) \_\_\_\_\_

## 5. TREATMENT ADMINISTERED

First Aid given       Yes       No

First Aider name: \_\_\_\_\_

Treatment: \_\_\_\_\_

Referred to: \_\_\_\_\_



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## SECTION 6-9 To be completed by WHS/RTW Coordinator/HR Manager

### 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):

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### 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): \_\_\_\_\_

Position: \_\_\_\_\_ 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: \_\_\_\_\_

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