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):

_____

_____

_____

_____

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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