

INJURY/INCIDENT REPORT FORM

This form is to be used to report all incidents/accidents.

SECTION A: TO BE COMPLETED BY PERSON INVOLVED OR MEDICAL OFFICER.

PERSON INVOLVED IN ACCIDENT/INCIDENT *(Please print)*

Surname:	First Name:	Date of Birth:
(please tick) Employee <input type="checkbox"/> Contractor <input type="checkbox"/> Volunteer <input type="checkbox"/> Visitor/Other <input type="checkbox"/>		Male <input type="checkbox"/> Female <input type="checkbox"/>
Department:	Position:	

DETAILS OF THE ACCIDENT **INCIDENT**
 (tick appropriate box)

Date accident/incident: ____ / ____ / ____.

Time accident/incident: _____ am/pm

Location where accident/incident occurred
 (please print):

Part of body affected (*tick appropriate answers*)

- | Head | Trunk | Internal | Arm | Hand | Leg | Foot |
|--------------------------------|-----------------------------------|-----------------------------------|------------------------------------|----------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> eye | <input type="checkbox"/> neck | <input type="checkbox"/> heart | <input type="checkbox"/> left | <input type="checkbox"/> left | <input type="checkbox"/> left | <input type="checkbox"/> left |
| <input type="checkbox"/> ear | <input type="checkbox"/> hip | <input type="checkbox"/> lungs | <input type="checkbox"/> right | <input type="checkbox"/> right | <input type="checkbox"/> right | <input type="checkbox"/> right |
| <input type="checkbox"/> nose | <input type="checkbox"/> chest | <input type="checkbox"/> systemic | <input type="checkbox"/> shoulder | <input type="checkbox"/> thumb | <input type="checkbox"/> knee | <input type="checkbox"/> great toe |
| <input type="checkbox"/> mouth | <input type="checkbox"/> stomach | | <input type="checkbox"/> upper arm | <input type="checkbox"/> fingers | <input type="checkbox"/> lower leg | <input type="checkbox"/> other toes |
| <input type="checkbox"/> teeth | <input type="checkbox"/> groin | | <input type="checkbox"/> elbow | <input type="checkbox"/> palm | <input type="checkbox"/> ankle | |
| <input type="checkbox"/> face | <input type="checkbox"/> back | | <input type="checkbox"/> forearm | | <input type="checkbox"/> thigh | |
| <input type="checkbox"/> skull | <input type="checkbox"/> multiple | | <input type="checkbox"/> wrist | | <input type="checkbox"/> upper leg | |

not applicable

Nature of Accident/Incident (*tick appropriate answers*)

- | | | | | | |
|-------------------------------------|-------------------------------------|---------------------------------------|----------------------------------|--------------------------------|--|
| <input type="checkbox"/> abrasion | <input type="checkbox"/> puncture | <input type="checkbox"/> heart attack | <input type="checkbox"/> sprain | <input type="checkbox"/> burn | <input type="checkbox"/> traumatic shock |
| <input type="checkbox"/> bruise | <input type="checkbox"/> laceration | <input type="checkbox"/> hearing loss | <input type="checkbox"/> strain | <input type="checkbox"/> scald | <input type="checkbox"/> electric shock |
| <input type="checkbox"/> fracture | <input type="checkbox"/> amputation | <input type="checkbox"/> foreign body | <input type="checkbox"/> hernia | <input type="checkbox"/> rash | <input type="checkbox"/> chemical |
| <input type="checkbox"/> concussion | <input type="checkbox"/> bite | <input type="checkbox"/> minor cuts | <input type="checkbox"/> Allergy | | |

Aggravation of previous injury or medical condition.

not applicable

Type of Accident/Incident (*tick appropriate answers*)

- | | | | | |
|---|------------------------------------|-----------------------------------|--|-------------------------------------|
| <input type="checkbox"/> striking against | <input type="checkbox"/> stumbling | <input type="checkbox"/> lifting | <input type="checkbox"/> pushing | <input type="checkbox"/> ingestion |
| <input type="checkbox"/> struck by | <input type="checkbox"/> slipping | <input type="checkbox"/> bending | <input type="checkbox"/> pulling | <input type="checkbox"/> absorption |
| <input type="checkbox"/> caught in | <input type="checkbox"/> tripping | <input type="checkbox"/> twisting | <input type="checkbox"/> jumping | <input type="checkbox"/> inhalation |
| <input type="checkbox"/> stepping on | <input type="checkbox"/> falling | <input type="checkbox"/> stress | <input type="checkbox"/> motor vehicle | |
| <input type="checkbox"/> other: describe | | | | |

not applicable

Agency of Accident/Incident (*tick appropriate answers*)

- | | | | |
|---|--------------------------------------|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Vehicle | <input type="checkbox"/> Buildings | <input type="checkbox"/> Mobile Plant | <input type="checkbox"/> Structures |
| <input type="checkbox"/> Power tools | <input type="checkbox"/> Furniture | <input type="checkbox"/> Other tools | <input type="checkbox"/> Surfaces |
| <input type="checkbox"/> Animal/Insect | <input type="checkbox"/> Heat Stress | <input type="checkbox"/> Materials | <input type="checkbox"/> Sunburn |
| <input type="checkbox"/> Biological agent | <input type="checkbox"/> Chemicals | <input type="checkbox"/> Equipment | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Objects | | <input type="checkbox"/> Other | |

not applicable

If reporting an incident, please describe how this occurred:

SECTION B: TO BE COMPLETED BY MANAGER AND THE PERSON INVOLVED.

This is an extremely important section as the aim of the accident/incident investigation is to identify preventative action that will avoid reoccurrence of a similar accident.

Probable cause or causes of Accident / Incident (*tick appropriate answers*)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> inadequate instruction | <input type="checkbox"/> fault of plant or equipment | <input type="checkbox"/> poor storage | <input type="checkbox"/> weather |
| <input type="checkbox"/> inadequate workspace | <input type="checkbox"/> equipment unavailable | <input type="checkbox"/> poor access | <input type="checkbox"/> terrain |
| <input type="checkbox"/> assistance unavailable | <input type="checkbox"/> lack of attention | <input type="checkbox"/> incorrect method | <input type="checkbox"/> work practices |
| <input type="checkbox"/> not applicable | | | |

Describe how the accident occurred:

PREVENTION OF ACCIDENT/INCIDENT RECURRENCE

Describe what action is planned or has been taken to prevent a recurrence of the accident.
(Please print)

(Immediate)

(Long Term)

SECTION C:

Manager name _____

Manager signature _____

Signed by person involved _____