

## INCIDENT AND INVESTIGATION REPORT

This form is used to report all accidents/incidents and near misses, whether an injury occurred or not and to document the investigation into the incident. Please complete this form as soon as possible after the incident occurred. Notifiable incidents must be reported to the Regulator immediately.

PART A: INJURED PERSON'S DETAILS (completed by person involved or by the Manager)							
Full name of injured person:			Date of birth				
Workers address:							
Department & location:							
Occupation:			Phone:				
<input type="checkbox"/> Employee	<input type="checkbox"/> Contractor		<input type="checkbox"/> Visitor	Company:			
DETAILS OF THE INCIDENT							
Date of incident/injury:		Time:		am / pm			
Exact location of incident:							
Operation & industry the worker/contractor was engaged in at time of incident:							
DETAILS OF TREATMENT (if any)							
<input type="checkbox"/> Medical Practitioner Details:			<input type="checkbox"/> Nil	<input type="checkbox"/> First Aid			
Details of treatment:			<input type="checkbox"/> Hospital Details:				
Was there any time lost (please tick)			<input type="checkbox"/> Nil	<input type="checkbox"/> YES	days		
Workers Compensation claim lodged:			<input type="checkbox"/> YES	<input type="checkbox"/> NO			
Regulator notified:			<input type="checkbox"/> YES	<input type="checkbox"/> NO			
CAUSE OF INJURY (tick box)			NATURE OF INJURY (tick box)				
<input type="checkbox"/>	Pushing / pulling	<input type="checkbox"/>	Moving plant	<input type="checkbox"/>	Cut	<input type="checkbox"/>	Fracture
<input type="checkbox"/>	Trip/slip/fall	<input type="checkbox"/>	Biological	<input type="checkbox"/>	Bruise	<input type="checkbox"/>	Burn
<input type="checkbox"/>	Falling object	<input type="checkbox"/>	Chemical	<input type="checkbox"/>	Sprain/ strain	<input type="checkbox"/>	Abrasion
<input type="checkbox"/>	Vehicle	<input type="checkbox"/>	Person/animal	<input type="checkbox"/>	Electric shock	<input type="checkbox"/>	Other (describe)
WHAT BODY PART WAS AFFECTED?							
<input type="checkbox"/>	Head	<input type="checkbox"/>	Hand (right)	<input type="checkbox"/>	Hand (left)	<input type="checkbox"/>	Fingers

<input type="checkbox"/>	Face	<input type="checkbox"/>	Knee (right)	<input type="checkbox"/>	Knee (left)	<input type="checkbox"/>	Ankle(right)
<input type="checkbox"/>	Eye (right)	<input type="checkbox"/>	Leg (right)	<input type="checkbox"/>	Leg (left)	<input type="checkbox"/>	Ankle (left)
<input type="checkbox"/>	Eye (left)	<input type="checkbox"/>	Nose	<input type="checkbox"/>	Ears	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	Trunk / Back	<input type="checkbox"/>	Foot (right)	<input type="checkbox"/>	Foot (left)	<input type="checkbox"/>	Other (describe)
<input type="checkbox"/>	Neck	<input type="checkbox"/>	Arm (right)	<input type="checkbox"/>	Arm (left)		

<b>PART B: THE INCIDENT (completed by Manager in consultation with injured person)</b>			
Describe what happened:			
Were they any witnesses: [please tick]		<input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, list names below)	
Name:		Phone:	
Name:		Phone:	
<b>INCIDENT ANALYSIS</b>			
What factors contributed to the incident: eg plant/equipment, work organisation, work methods, worker behaviour and environment?			
<b>PREVENTION</b>			
What was the IMMEDIATE action taken following the incident? Can you eliminate the hazard?			
What action will be taken to prevent a recurrence? Implement controls using the hierarchy of controls. (Refer to the WHS risk management procedure)			

Corrective action follow up. Check that controls are effective in minimising the risk.

**COMPLETION OF INVESTIGATION**

<b>Incident Investigated by:</b>	<b>Name:</b>	<b>Position:</b>
	<b>Signature:</b>	<b>Date:</b>
<b>Workers Manager</b>	<b>Name:</b>	<b>Position:</b>
	<b>Signature:</b>	<b>Date:</b>
<b>Injured Worker</b>	<b>Name:</b>	<b>Position:</b>
	<b>Signature:</b>	<b>Date:</b>

Return completed form to \_\_\_\_\_