



Incident and Hazard Report Form

To be completed in the event of a worker witnessing/being involved in any non-conformance, or an incident, or resulting, or potentially resulting, in an injury or an unsafe practice or a near hit.

Personal details of persons involved in incident:

Staff

Full Name:

Position Title:

Managers Name:

Student = Student ID Number:

Contractor = Company Name:

Visitor, please specify:

Other, please specify:

Incident details *(completed by person involved)*

Date of incident:

Time of incident:

Location of incident:

Description of incident: *(in your own words, what happened?)*

Name of witnesses to the incident

Name:

Contact:

Name:

Contact:

Name:

Contact:

Details of injuries sustained

Injured person's name:

Type of injury:

Treatment received:

Injured person's name:

Type of injury:

Treatment received:

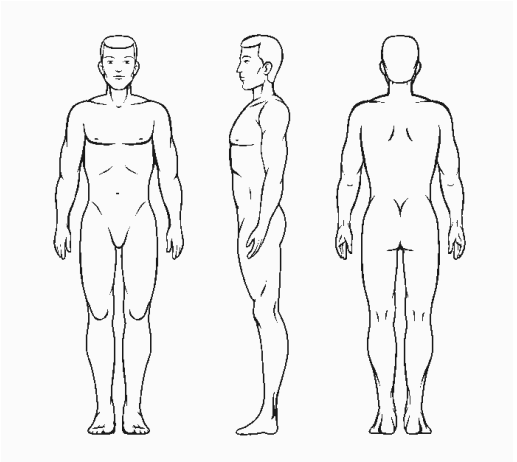
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Date:	Location:	Time In:		
Casualty's Family Name:	Given Name:	Sex:	DOB:	
Patient Address:		Telephone:		
Allergies?		Medication?		
What happened? How, Where, When?				
Witness Family Name:		Given Name:	Telephone:	
Past Medical History	Not Known	Asthma	Cardiac	Diabetic
	Nil	Epilepsy	Hypertension	Loss of consciousness
	Others? _____	Medi Alert- What? _____		

TIME	BREATHING	PULSE	CONSCIOUS LEVEL		OTHER OBSERVATION
			ALERT VOICE PAIN UNCONSCIOUS		

<p>A abrasion Bl bleeding Bu burns C contusion D deformity F fracture L laceration P pain S swelling T tenderness</p>		<p>Treatment:</p>
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Rufused Treatment: Witness and Signature: _____

Discharged How?	Ambulance	Hospital	Return to work	others _____
First Aiders Name and Signature:		Patient Signature:		Time out:

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Details of other person's involved

Did the incident involve any other person? Yes No

(If yes, provide their name and contact details):

Details of any damage

Did any damage to property occur? Yes No

(If yes, provide details of the damage):

Other details

Were the Police involved? Yes No

(If yes, provide details of the officers attending):

Was the State Safety Regulator (WorkCover) informed? Yes No

Is this a workers compensation related incident? Yes No

.....
Name *(completed by person submitting report)*

.....
Signature

.....
Date

.....
Name *(completed by witness)*

.....
Signature

.....
Date

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OFFICE USE ONLY

Corrective action plan: what needs to be done to minimise risk / prevent this incident from happening in the future? Document follow-up action taken after receipt of the incident report.

Action Required	Due Date	Responsible person

Final comments regarding corrective action taken (To be completed by the Responsible Person)

Further follow up required or other comments:

Any other persons who are involved in this case has been notified of updates, changes and corrective actions
The above has been completed and this case is now closed

.....
Responsible person name

.....
Signature

.....
Date

Human Resources Representative

This report has been saved into the staff / student file

This report has been logged in the Incident Report Register

.....
Staff Name

.....
Signature

.....
Date

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