

## CONFIDENTIAL INCIDENT/INJURY REPORT FORM – PART 1

**To Be Completed by the person or persons directly involved**

**PART 1: Instructions:**

Person reporting to follow the Incident and Accident Policy. Then complete this report and provide it to the site manager within one hour or as soon as practical.

**Section A: PERSONAL and INCIDENT DETAILS** (Circle or complete responses)

Title:	Last Name:	Other names:
Date of Birth:	Are you: employee / contractor / visitor	
Sex: M/F/Other		Occupation:
Email address:	Ph: (w)	Ph: (h)
Home address:		Post code:
Date and time of incident:     /     /     : am / pm	Location:	
How did the incident happen?		
Signed:		Date:
Name(s) of witness:		Ph:

**Section B: SUPERVISOR OR SITE MANAGER NOTIFICATION**

Name of Health and Safety Representative:		Date and time notified     /     /     : am/pm	
Signed:	Date:     /     /	Ph:	
Name of Supervisor:		Date and time notified     /     /     : am/pm	
Signed:	Date:     /     /	Ph:	

**Section C: INJURY DETAILS** (If applicable) *Use this section to also report workplace disease*

Type of injury or disease (eg burn):	Part(s) of the body affected:
Date and time when symptoms noticed:     /     /     : am/pm	
Was medical treatment given?	No / First Aid / Nurse / Doctor / Hospital
Name of person giving initial treatment:	
Date and time initial treatment given:     /     /     : am/pm	
Does the injured person intend to lodge a claim for workers' compensation Yes / No / Unknown	
Will time be lost as a result of the injury?     Yes / No	How many hours/days?

## INVESTIGATION CHECKLIST AND ACTION REPORT FORM – PART 2.

Who is involved in completing this investigation?

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### Section 1: INVESTIGATION CHECKLIST:

Incident / Injury: How do you think the incident / injury happened and what were you doing at the time?

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How long had you been working prior to the incident / injury? \_\_\_\_\_

How long had you been working on this task? \_\_\_\_\_

Is this task part of your normal duties?      Yes    No

Have you been instructed / trained in this task?    Yes    No

What were you doing in the time prior to the incident / injury?

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Are there any other factors involved (management, the environment, equipment, maintenance, individual)?

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What do you think could have been done to prevent this incident from occurring?

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Any other comments or observations?

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**Please circle the most appropriate response/s:**

<b>What sort of incident/injury occurred?</b> Manual Handling / Occupational Overuse Syndromes (OOS) / cuts / bruises / burns / falls / slips / trips / vehicles / bicycles / chemicals / insects / animals / foreign body / plant / stress/ other....
<b>Location where incident occurred?</b>
<b>Type of injury:</b> sting / bite / kick / puncture / strain / sprain / chemical / slip / trip / fall / other...
<b>Safe Work Procedures followed?</b> <span style="float: right;">Yes / No / N/A</span>
<b>Identification of equipment/object/insect involved:</b>
<b>Equipment in good condition?</b> <span style="float: right;">Yes / No / N/A</span>
<b>Date of last service of equipment:</b>

<b>Appropriate safety equipment (PPE) used?</b>	Yes / No / N/A
<b>Lighting adequate?</b>	Yes / No / N/A
<b>Housekeeping issues contributed?</b>	Yes / No / N/A
<b>Confined space?</b>	Yes / No / N/A
<b>Surface type:</b> cement / tile / grass / dry / wet / damaged / torn / sand / footpath / carpet / gravel / rocks / road / other...	
<b>Type of shoes worn:</b> open / closed / boots / high heels / sandals / none / other...	
<b>Workload excessive?</b>	Yes / No / N/A
<b>Workload boring and repetitive?</b>	Yes / No / N/A
<b><u>If it was a slip or trip:</u></b> Height of fall /slip / trip?	
Were you running / walking / turning a corner / jumping / other?	
If stairs going up / going down?	
Did you fall on your front / back / side?	
What were you carrying (if anything) at the time?	
<b><u>If the incident involved chemicals:</u></b> Was an MSDS (Material Safety Data Sheet) available?	Yes / No / N/A
Disposal / handling / storage of chemical product adequate?	Yes / No / N/A
<b><u>If the incident involves manual handling:</u></b> Were work items within easy reach?	Yes / No / N/A
Ergonomic equipment available?	Yes / No / N/A
Was the equipment being used correctly?	Yes / No / N/A
Repetitive and/or forceful movements used?	Yes / No / N/A
Action involved reaching / bending / stooping / sitting / kneeling / twisting / pushing / pulling / lifting / catching / lowering / carrying	
Weight of object?	
Distance carried/ position of object moved from/to?	
Height of load?	
<b><u>If the incident involves a vehicle or bicycle:</u></b> traffic conditions:	
Weather conditions: dry / wet / foggy / night / day	
Intersection / turning right or left / driveway / straight road	
Speed prior to accident?	
Travelling: to work / lunch time / after work / to course / work related travel	
<b>Any other factors involved?</b>	

### Section 3: To Be Completed by the OHS Officer

**Investigator's comments and observations from section 1:**

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**RECOMMENDATIONS:** A hierarchy of control should be used to assist with the prevention of future similar injuries. The 'hierarchy of control' depicts the most to the least effective methods, as shown in the table below.

**This is the most important part of the investigation process! Do not leave blank.**

Risk Control Options	Action Required	By Whom	By When
Elimination – do you have to do the task?			
Substitution – is there another way you can do the task?			
Engineering – can you engineer a way to make the job safer?			
Administration – can you improve work practices? E.g. limit time of exposure.	↓		
Personal Protective Equipment (PPE)			
Date feedback provided to person reporting the injury/incident:    /    /			
Signed:		Print Name:	Ph:
Position:		Date:        /        /	

Office Use Only    (Health and Safety Recommendations)

OT	Date Part 2 received:    /    /	Date Completed:    /    /

