



Incident / injury report form

Please print clearly and tick the correct box

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:	

3. 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:		

SECTION 6-9 MUST BE COMPLETED BY EMPLOYER

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6. DID THE INJURED PERSON STOP WORK ?

Yes	No If yes, state date:	Time:
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Outcome:

Treated by doctor	Hospitalised	Workers compensation claim
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Returned to normal work	Alternative duties	Rehabilitation
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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):	Title: _____
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	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: