**ACCIDENT / INCIDENT / NEAR MISS REPORT**

Note: This report must be completed within 24 hours of the occurrence.

**SECTION A: Injured person details (Employee/Supervisor to complete)**

|  |  |
| --- | --- |
| Family name: | Given name: |
| Usual work location: | Occupation/Job title: |
| Date of Birth: | Mail/Female: |
| Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postcode:\_\_\_\_\_\_\_\_ | Telephone Contact: |
| Will there be a WorkCover claim submitted (Yes/No)? |

**SECTION B: Incident details (Supervisor to fill out) (Note: if not applicable, put “N/A”)**

|  |
| --- |
| Type: |
| * Injury to employee/contractor
 | * Injury to member of public
 |
| * Damage to machinery, property, etc
 | * Near miss
 |
| Ownership |
| Was damaged machinery, property, etc owned by InsulAction? (Yes/No) |
| Details |
| Incident date: | Incident time: |
| Date incident reported: | Time incident reported: |
| Date ceased work: | Time ceased work: |
| Name, address and contact telephone of witnesses |
| Witness 1: |
| Witness 2: |
| Machinery, property identification (eg rego, address) |  |
| Describe incident details (see “useful tips” for guidance) – if insufficient space attach report/diagrams: |
| Severity of injury: |
| * Near Miss
 | * First aid
 | * Ambulance
 | * Medical treatment
 |
| * Hospital
 | * Lost time
 | * Plant/equip/machinery
 | * Motor vehicle
 |
| Part of body: |
| * Head
 | * Ear
 | * Neck
 | * Eye
 | * Back
 |
| * Chest/abdomen
 | * Shoulder
 | * Hip
 | * Upper arm
 | * Elbow
 |
| * Wrist
 | * Finger
 | * Hand
 | * Leg
 | * Knee
 |
| * Ankle
 | * Foot
 | * Toe
 | * Multiple
 |  |
| * Other (describe):
 |
| Assessed nature of injury: |
| * Concussion
 | * Deafness
 | * Eye disease/condition
 | * Dislocation
 |
| * Sprain/strain
 | * Bruising
 | * Laceration
 | * Fracture
 |
| * Burns/scalds
 | * Electric shock
 | * Crushing
 | * Skin irritation
 |
| * Blood pressure
 | * Veins/circulation
 | * Digestive system
 | * Muscoskel disease
 |
| * Toxic substances
 | * Respiratory
 | * Hernia
 | * Internal organ
 |
| * Multiple
 | * Superficial
 |  |  |

|  |
| --- |
| **Contributing factors** |
| * Hazard not identified
 | * Exposure to fumes, mist, vapour, dust
 | * Contact chemical/poisons
 |
| * Contact hot/cold substances/object
 | * Slips, trips, falls from height
 | * Slips, trips, falls from same level
 |
| * Striking against object
 | * Struck by moving object
 | * Struck by falling object
 |
| * Caught by stationary object
 | * Caught by machine or object
 | * Caught between moving object
 |
| * Incorrect placement of materials
 | * Insect/animal bite
 | * Deficiency of plant/equip
 |
| * Vehicles
 | * Manual handling
 | * Incorrect work method
 |
| * Insufficient training
 | * Exposure to noise
 | * Mental stress
 |
| * Physical assault
 | * Verbal assault
 | * Contact with electrical current
 |
| * Contact with ionising radiation
 | * Contact with radiation (other)
 | * Explosion/Implosion
 |

**SECTION C: Risk Assessment and Preventative Action(s) (Supervisor to fill out) – see “instructions” for assistance with this.**

|  |
| --- |
| Level of Risk (\* Priority: H=Immediate action / M=Medium term / L=Future Action) |
| Estimate the probability of the incident/hazard occurring again based on experience and previous incident/hazard data (tick one) | What is the severity of the actual or potential injuries or damage to equipment/machinery/property/etc (tick one) |
| * Low
 | * Medium
 | * High
 | * Low
 | * Medium
 | * High
 |
| Recommendations to prevent reoccurrence | Priority \* | Who | When by |
|  | * H
 | * M
 | * L
 |  |  |
|  | * H
 | * M
 | * L
 |  |  |
|  | * H
 | * M
 | * L
 |  |  |
|  | * H
 | * M
 | * L
 |  |  |
|  | * H
 | * M
 | * L
 |  |  |
| Media/authorities involved? (Provide details) |

**SECTION D: Signatories & Distribution of completed form**

|  |  |  |
| --- | --- | --- |
| (Print name) |  |  |
| Manager/Supervisor  | (Signature) | Date |
| (Print name) |  |  |
| OH&S Representative  | (Signature) | Date |
| After signing & dating, please distribute the completed form as follows: |
| **Original:** Workplace Injury Register folder | **1st Photocopy:** Regional Manager |
| 2nd Photocopy: HR Manager | **3rd Photocopy:** Injured employee |

**SECTION E: OH&S Manager Inspection**

|  |  |
| --- | --- |
| Incident No: | Inspection Date: |
| Comments: |
| (Print name) |  |  |
| HR Manager | (Signature) | Date |