



Register of Incident/Accident Report

To be completed for Incidents that result in Injury OR Near Miss

Time & Date of Incident: Date: ___/___/___ ___:___ am/pm Mon Tues Wed Thur Fri Sat Sun	Site where Incident/Accident occurred:
Business eg. Office Serv.; Ind.; Fin.;	Investigating Supervisor/Manager:
Precise Location:	Contact Phone Number:

Surname of Person/s Involved in the occurrence: (block letters)

Given Names:

.....

Name & telephone number of witnesses:

..... Employee Other

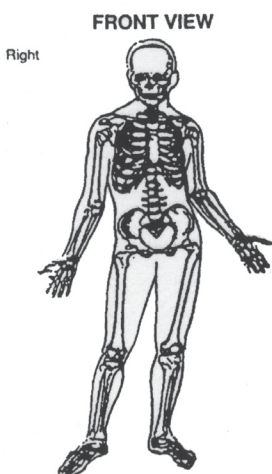
..... Employee Other

The Occurrence (where and how did incident/accident occur)

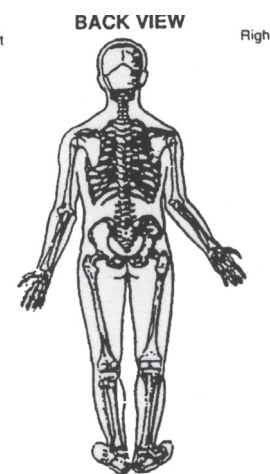
Outcome of Occurrence
(nature of injury/disease/damage to equipment or property)

Location of Injury (Indicate the location on body map)

FRONT VIEW



BACK VIEW



Nature of Injury:

<input type="checkbox"/> Laceration	<input type="checkbox"/> Burn	<input type="checkbox"/> Disease*
<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Fracture	<input type="checkbox"/> Bruising
<input type="checkbox"/> Foreign Body	<input type="checkbox"/> Poisoning*	<input type="checkbox"/> Gas Inhalation*
<input type="checkbox"/> Impact with Plant/Machinery	<input type="checkbox"/> DEATH*	
<input type="checkbox"/> Other		

Agency of Injury:

<input type="checkbox"/> Person - Fall/Strike	<input type="checkbox"/> Object-Fall/Strike	<input type="checkbox"/> Plant*
<input type="checkbox"/> Electricity*	<input type="checkbox"/> Work Environ*	<input type="checkbox"/> Power Tools*
<input type="checkbox"/> Manual Handling	<input type="checkbox"/> Substance Contact*	<input type="checkbox"/> Crush/Entrap*
<input type="checkbox"/> Failure of Structure*		
<input type="checkbox"/> Other		

Treatment: Nil First Aid Medical treatment at Clinic Medical treatment at Hospital* Lost Time*

How long in this job/work? ___ years ___ months ___ days ___ hours

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Safety Equipment

Was Personal Safety Equipment used? Yes No If yes, type:

Was Personal Safety Equipment adequate? Yes No If no, why not?.....

Major contributory factors: (what contributed to the incident/accident?)

Design	Behavior	Environment	Management
<input type="checkbox"/> Laceration <input type="checkbox"/> Ventilation <input type="checkbox"/> Noise <input type="checkbox"/> Machinery, Tools, Equipment, etc* <input type="checkbox"/> Manual Handling (size, weight, position, etc) <input type="checkbox"/> Work Area <input type="checkbox"/> Malfunction or Defect in machinery, tools or equipment* <input type="checkbox"/> Safety Clothing or Equipment	<input type="checkbox"/> Fatigue/Stress <input type="checkbox"/> Physical Disability <input type="checkbox"/> Intentional Act <input type="checkbox"/> Skylarking or Misconduct <input type="checkbox"/> Possible Personal problems <input type="checkbox"/> Inexperience <input type="checkbox"/> Failure to use Prescribed Safety Equipment <input type="checkbox"/> Work Method Used <input type="checkbox"/> Alcohol or Drugs	<input type="checkbox"/> Ambient Conditions (wind, dust, rain, etc) <input type="checkbox"/> Terrain <input type="checkbox"/> Temperature <input type="checkbox"/> Housekeeping <input type="checkbox"/> Building Surface Conditions (stairs, floors, etc) <input type="checkbox"/> Storage/Stacking of Materials* <input type="checkbox"/> Exposure or Contact with Chemicals or other Agents* <input type="checkbox"/> Exposure to Infectious Sickness/Disease*	<input type="checkbox"/> Safe Operation Procedure <input type="checkbox"/> Supervision <input type="checkbox"/> Prescribed Safety Equipment or Clothing <input type="checkbox"/> Plant or Equipment <input type="checkbox"/> Maintenance <input type="checkbox"/> Suitable Plant/Equipment <input type="checkbox"/> Instructions or Information

See attached pages (numbered) for more Details

* **Report immediately to National Occupational Risk Manager for assistance in the preparation of Legislative requirements to report to the WorkCover Inspectorate.**

Worker Training: Induction: Yes No
 Job Specific (safe operation procedures): Yes No

Have the "trained" safe operation procedures been followed? Yes No

If "No", why not?.....

Summary of investigation observations: (cause of the incident /accident occurrence) [Attach sep sheet if insufficient room]

Specific preventative actions: (taken/recommended) (Attach sep sheet if insufficient room)

Person responsible for implementing prevention actions /controls

Have they been notified of required preventative action? Yes No Implementation by:/...../.....

Signatures:

Person/s involved: Date:

Investigating Supervisor/Manager: Date:

H&S or Other Employee Representative: Date:

Forward completed Report with photos, diagrams etc. to the National Occupational Risk Manager. COPIES of the report to the Incident Report Register and Person's involved.