

Incident Report Form (Accident, Incident or Near-Miss)



Description of what occurred

Type of Incident			
<input type="checkbox"/> Accident	<input type="checkbox"/> Near-Miss	<input type="checkbox"/> Property Damage	<input type="checkbox"/> Minor Injury
<input type="checkbox"/> First Aid	<input type="checkbox"/> Medical Treatment Injury	<input type="checkbox"/> Hospitalisation	<input type="checkbox"/> Other

Person Completing Report	
Name:	Position:

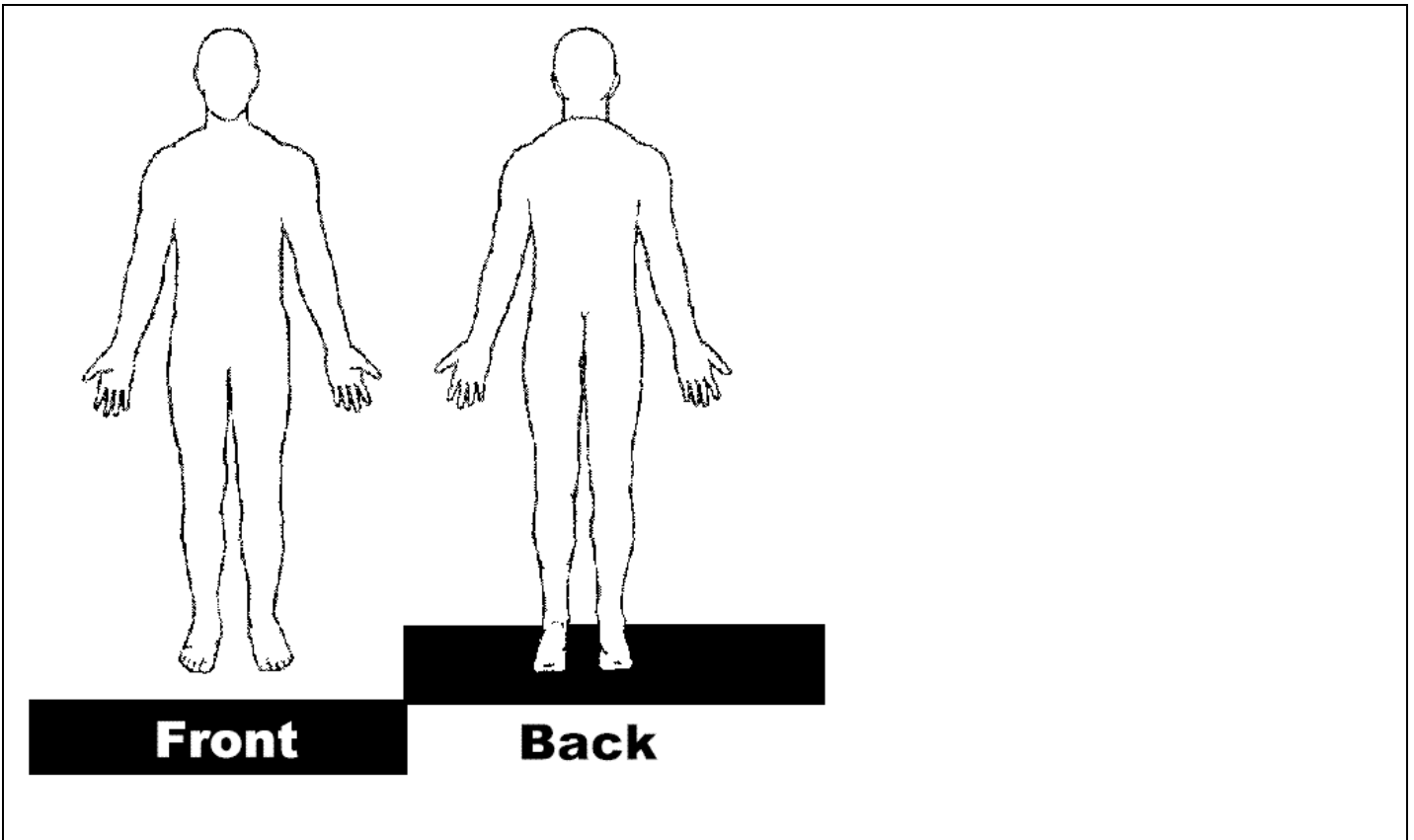
Affected Person Details <i>(if applicable)</i>	
Name:	Position:

The Accident, Incident or Near-miss or Hazard Details	
Date occurred/observed: / /	Time occurred/observed: <input type="checkbox"/> AM <input type="checkbox"/> PM

The location where the incident / near-miss occurred (Please provide the exact location)

Description of any injury (Please be specific and add detail to the picture below)

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**Describe the circumstances that led to the incident or near-miss?
(What was the injured/affected person doing? How did the incident occur?)**

Witness/s

Name:	Position:
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Has a statement been taken and attached? YES NO

Name:	Position:
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Has a statement been taken and attached? YES NO

WorkCover Claim Lodged? YES NO Not Applicable

Incident/Hazard Investigation

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The person responsible for the investigation	
Name:	Position:
Why did the incident/near-miss occur?	
What was the 'actual' cause of the incident or the near miss?	
What were the contributing factors?	
Risk Control Strategy – What are we doing to reduce the risk of reoccurrence?	
Can you eliminate the hazard? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<i>Comment:</i>	
Can you modify or change the workplace environment, SWMs, SOPs, equipment, etc. currently being used for the job/task being undertaken to reduce the risk of injury? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Not Applicable	
<i>Comment:</i>	
Can you introduce training, job rotation, signage, personal protective equipment (PPE), etc. to reduce the worker's exposure to the hazard? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Not Applicable	
<i>Comment:</i>	
Has the above been completed? <input type="checkbox"/> YES <input type="checkbox"/> NO	
What is the action plan?	
The person responsible and due date?	
Name:	Position:

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Due Date:	
Date investigation completed: / /	
Safety Committee Team Member Sign-off:	Date: / /

On completion of the investigation, the injured worker’s manager is to send a copy of the Incident Report Form to General Manager and Managing Director to review the incident and investigation and file a copy of the form and any documents associated with the investigation in the OH&S reporting folder.