KEYS
HUMAN RESOURCES

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INCIDENT REPORT FORM

DEATILS OF INJURED PERSON

Name: _____ Phone: _____

Address: _____

DOB: _____ Sex: □ Male □ Female

Position Held: _____ Start Time: □ AM □ PM

Work Classification: □ Casual □ Part Time □ Full Time

DETAILS OF INCIDENT

Date: _____ Time: _____

Location/Job Site: _____

Describe what happened and how: _____

□ Personal Injury □ Near Miss □ Hazardous Substance □ Act of Violence

DETAILS OF WITNESSES

Name: _____ Phone: (M) _____ (H)_____

Address: _____

DETAILS OF INJURY

Nature of injury: _____

Cause of injury: _____

Location on body: _____

TREATMENT ADMINISTERED

Was First Aid administered: □ Yes □ No If so, please complete First Aid Report

First Aider name: _____

Treatment administered: _____

Referred to: _____

SECTION 6 – 9 TO BE COMLETED BY EMPLOYER

DID THE INJURED PERSON STOP WORK?

□ Yes □ No If yes, state date: _____ Time: _____

Outcome:

□ Treated by Doctor □ Hospitalised □ Workers Compensation Claim

□ Returned to Normal Work □ Alternative Duties □ Rehabilitation

INCIDENT INVESTIGATION (Comments to include casual factors):

_____

_____

_____

_____

RISK ASSESSMENT

Likelihood of Reoccurrence: _____

Severity of outcome: _____

Level of risk: _____

ACTIONS TO PREVENT REOCURRENCE

Action	By Whom	By When	Date Completed

ACTIONS COMPLETED

Signed (Manager): _____ Title: _____

Print Name : _____ Date: _____

REVIEW COMMENTS

OHS Committee/Staff Meeting: _____

Reviewed by Site Manager (Signed): _____ Date: _____

Reviewed by Health & Safety Representative (Signed): _____ Date: _____