INCIDENT REPORT FORM

To be completed in the event of a worker witnessing/being involved in any non-conformance, or an incident, or resulting, or potentially resulting, in an injury or an unsafe practice or a near hit.

Personal details

Surname:	First name(s):	DOB:
Position:		
Managers Name:		
Address:		
Telephone number (landline):		
Telephone number (mobile):		
Email address:		

Incident details *(completed by person involved)*

Date of incident:	Time of incident:
Description of incident: *(in your own words, what happened?)*	
Location of incident:	

Name of witnesses to the incident

Name:	Contact:
Name:	Contact:
Name:	Contact:

Details of injuries sustained

Injured person's name:

Type of injury:

Treatment received:

Injured person's name:

Type of injury:

Treatment received:

Details of other persons involved

Did the incident involve any other person?	○ Yes	○ No

(If yes, provide their name and contact details)

Details of any damage

Did any damage to property occur?	○ Yes	○ No

(If yes, provide details of the damage)

Other details

Were the Police involved?	○ Yes	○ No

(If yes, provide details of the officers attending)

Was the State Safety Regulator (WorkCover) informed?	○ Yes	○ No
Is this a workers compensation related incident?	○ Yes	○ No

What do we do following the incident?

Actions	Proposed?	Taken?
Change to induction		
Change to ongoing training		
Change to work procedure		
Change to work environment		
Equipment maintenances		
Job re-design		
Site clean up		
Risk assessment review		
Other preventative action		

Corrective actions

Describe what needs to be done	Who is responsible?	Date for completion

Consultation

Who did we consult with when deciding on the actions for the controls?

Name	Position	Contact details (phone)

Authorisation of corrective action

Name	Signature	Date