



HOW TO COMPLETE AQC INCIDENT REPORT FORM

NAME					SURNAME		
Status	<input type="checkbox"/> Employee	<input type="checkbox"/> Contractor	<input type="checkbox"/> Student	<input type="checkbox"/> Volunteer	<input type="checkbox"/> Visitor		
Payroll #		Location		Supervisor Manager			
If Contractor: name and address of Contractor				If Visitor or Volunteer: name and phone number			
WITNESS (If any)							
Witness Name				Mobile /Phone			
Date of Incident	/	TIME		Where it occurred			
Date Reported	/	TIME					
CAUSE OF INJURY							
<input type="checkbox"/> Aggression/assault		<input type="checkbox"/> Consumer - manual handling		<input type="checkbox"/> Hitting an object			
<input type="checkbox"/> Exposure to chemical		<input type="checkbox"/> Consumer – Aggression/assault		<input type="checkbox"/> Exposure to electricity			
<input type="checkbox"/> Fall on even surface		<input type="checkbox"/> Hit by object/trapped by moving object		<input type="checkbox"/> Exposure to Radiation			
<input type="checkbox"/> Fall from height		<input type="checkbox"/> Uncapped Needle/needle stick		<input type="checkbox"/> Noise			
<input type="checkbox"/> Slip/Trip		<input type="checkbox"/> Mental Stress factors		<input type="checkbox"/> Repetitive work			
<input type="checkbox"/> Insect/Animal bite		<input type="checkbox"/> Vehicle Accident		<input type="checkbox"/> Muscle stress /load			
<input type="checkbox"/> Other:							
NATURE OF INJURY							
<input type="checkbox"/> Allergy/Sensitivity		<input type="checkbox"/> Hearing Loss		<input type="checkbox"/> Respiratory			
<input type="checkbox"/> Bruising		<input type="checkbox"/> Post -Traumatic Stress		<input type="checkbox"/> Skin condition			
<input type="checkbox"/> Burn/scald		<input type="checkbox"/> Fracture/Dislocation		<input type="checkbox"/> Internal injury			
<input type="checkbox"/> Concussion		<input type="checkbox"/> Superficial wound/abrasion		<input type="checkbox"/> Nausea/Vomiting			
<input type="checkbox"/> Contusion/crush		<input type="checkbox"/> Needle stick/sharps injury		<input type="checkbox"/> Sprain Strain			
<input type="checkbox"/> Electric shock/effects		<input type="checkbox"/> Occupational overuse		<input type="checkbox"/> Psychological			
<input type="checkbox"/> Exposure to heat/cold		<input type="checkbox"/> Poisoning/Toxic effect		<input type="checkbox"/> Vision impairment			
<input type="checkbox"/> Fainting		<input type="checkbox"/> Laceration/Deep cut		<input type="checkbox"/> Other:			
BODY LOCATION							
<input type="checkbox"/> Ankle		<input type="checkbox"/> Eye		<input type="checkbox"/> Hand		<input type="checkbox"/> Shin/Calf	
<input type="checkbox"/> Back		<input type="checkbox"/> Face		<input type="checkbox"/> Head		<input type="checkbox"/> Shoulder	
<input type="checkbox"/> Buttock		<input type="checkbox"/> Finger/Thumb		<input type="checkbox"/> Internal		<input type="checkbox"/> Stomach/trunk	
<input type="checkbox"/> Chest		<input type="checkbox"/> Foot/Toes		<input type="checkbox"/> Knee		<input type="checkbox"/> Thigh	
<input type="checkbox"/> Ear		<input type="checkbox"/> Forearm		<input type="checkbox"/> Neck		<input type="checkbox"/> Upper arm	
<input type="checkbox"/> Elbow		<input type="checkbox"/> Groin/Hip		<input type="checkbox"/> Not applicable		<input type="checkbox"/> Wrist	
TREATMENT OF INJURY							
<input type="checkbox"/> None required				<input type="checkbox"/> Attended A & E (treated as an outpatient)			
<input type="checkbox"/> On site First Aid (remained at work)				<input type="checkbox"/> Counselling/ Debriefing			
<input type="checkbox"/> On site First Aid (sent home)				<input type="checkbox"/> Hospitalised (admission)			
<input type="checkbox"/> Medical Treatment (referred to GP)				<input type="checkbox"/> Other personal support			

The name of who the incident/accident happened to.

Witness is who was present when the event occurred.

Cause of injury is asking you to identify why the incident/accident occurred. If cause of injury isn't listed, please tick other and write the reason. E.g. Extreme pain, catheter sore or leaking.

Nature of injury is identifying the nature of the incident/accident that has occurred. E.g. Back pain

Body location if a physical incident/accident has occurred. E.g. back, stomach

Treatment of injury is asking what treatment was required to assist the incident/accident. E.g. Hospitalized due to pain



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DESCRIBE THE EVENT THAT LEAD TO THE INJURY AND HOW IT OCCURRED (and any contributing factors)

Description area needs as much information as possible. Time arrived at shift, what events happened prior to incident/accident happening, what signs/symptoms you seen before you were aware of incident. What you did to help at the time. We need a step-by-step rundown of how everything went. What you did to assist/help. What contributed to the event occurring and how you knew that the incident had happened. This is a legally binding document, please provide as much detail as possible.

What action was taken?
Need to explain what event took place after the incident/event occurred e.g.
Ambulance was called or GP appointment was booked.

Was incident reported to office or anyone?
What is their position in AQC?

Legally needs to be signed and dated on completion.

IMMEDIATE ACTION TAKEN

Reported to:		Position:	
Completed by:		Signature:	
		Date:	



Management fills in this section, please do not attempt to complete.



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Office Use only				
Entered date / /		Name		RTW pack <input type="checkbox"/> No <input type="checkbox"/> Yes Signature Date

Please take into account that an incident report is a legally binding document, it needs to include as much information as possible to not only cover us as a business but yourself as an employee.