

Incident Form

Section A: Reporter Details

Form Completed By:	
<input type="checkbox"/> Student	<input type="checkbox"/> Staff Member (Full-time / Part-time / Casual / Contractor)
<input type="checkbox"/> Other (please specify) _____	
Are you involved in the incident?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Personal Information			
Full Name			
Contact Number		Email Address	
Supervisor/Manager (if applicable)			

Section B: Incident Details

Location of the Incident	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> On Campus (Building: _____ Room: _____ Specific Location: _____) <input type="checkbox"/> Off Campus (Address / Venue: _____) <input type="checkbox"/> Online (Platform: _____)	
Time of Incident	
Incident Reporting Date	
Type of Incident (tick all that apply): <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> Injury/Illness</div> <div style="width: 50%;"><input type="checkbox"/> Hazard</div> <div style="width: 50%;"><input type="checkbox"/> Near Miss</div> <div style="width: 50%;"><input type="checkbox"/> Fire/Explosion</div> <div style="width: 50%;"><input type="checkbox"/> Property Damage</div> <div style="width: 50%;"><input type="checkbox"/> Security Incident</div> <div style="width: 50%;"><input type="checkbox"/> Workplace Violence / Aggression</div> <div style="width: 50%;"><input type="checkbox"/> Vehicle Event</div> <div style="width: 50%;"><input type="checkbox"/> Environmental Event</div> <div style="width: 50%;"><input type="checkbox"/> Spill</div> <div style="width: 50%;"><input type="checkbox"/> Non-Academic Conduct</div> </div> Other (please specify) _____	

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Incident Details
<p><i>Provide a detailed description of what occurred, who was involved, and any known contributing factors.</i></p>
<p>Contributing Factors (if known):</p> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> Inadequate equipment</div> <div style="width: 50%;"><input type="checkbox"/> Inadequate procedures/instructions</div> <div style="width: 50%;"><input type="checkbox"/> Inadequate training</div> <div style="width: 50%;"><input type="checkbox"/> Inadequate supervision/management</div> <div style="width: 50%;"><input type="checkbox"/> Unsafe work environment</div> <div style="width: 50%;"><input type="checkbox"/> Inappropriate actions/behaviour</div> <div style="width: 100%;"><input type="checkbox"/> Other: _____</div> </div>
<p>Supporting Evidence Available?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If yes, please specify: <input type="checkbox"/> Photo <input type="checkbox"/> Video <input type="checkbox"/> Other: _____)</p>

Section C: People Involved (if applicable)

Role Type			
<div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"><input type="checkbox"/> Student</div> <div style="width: 33%;"><input type="checkbox"/> Staff (Full-time / Part-time / Casual / Contractor)</div> <div style="width: 33%;"><input type="checkbox"/> Visitor</div> <div style="width: 33%;"><input type="checkbox"/> Public</div> <div style="width: 33%;"><input type="checkbox"/> Other (please specify) _____</div> </div>			
Name(s) of People Involved			
Contact Number (if known)		Email:	
Witnesses (if any)			
Contact Number:		Email:	
<p>Privacy and Confidentiality</p> <p>All personal information collected in this form will be managed confidentially in accordance with the <i>Records Retention Policy</i> and the <i>Privacy Act 1988 (Cth)</i>. Access will be restricted to authorised personnel directly involved in incident management, investigation, and compliance reporting.</p>			

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Section D: Injury/Illness Details (if applicable)

Details of injury/illness (if any):			
Nature of injury (tick all that apply): <input type="checkbox"/> Cut <input type="checkbox"/> Bruise <input type="checkbox"/> Burn <input type="checkbox"/> Fracture <input type="checkbox"/> Sprain/Strain <input type="checkbox"/> Bite/Sting <input type="checkbox"/> Other: _____			
Body location affected:			
Level of treatment (tick one): <input type="checkbox"/> Report only <input type="checkbox"/> First aid <input type="checkbox"/> Medical treatment <input type="checkbox"/> Intend to seek medical treatment <input type="checkbox"/> Lost time injury			
Was first aid provided?		<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, by whom?)	
Was medical assistance required?		<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please specify (e.g., hospital/clinic))	
Treatment Provider/First Aider Signature			Date

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Section E: Actions Taken

Immediate actions taken:			
Were emergency services contacted? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please specify)			
Corrective / preventive actions (tick all that apply): <input type="checkbox"/> Elimination <input type="checkbox"/> Substitution <input type="checkbox"/> Engineering <input type="checkbox"/> Administration <input type="checkbox"/> PPE			
Description of action(s):			
Person Responsible:		Target Date of Completion:	
Action Completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date	

Section F: Acknowledgement and Declaration

Declaration			
By signing below, I acknowledge and confirm the following: i) That the information that I have provided in this Form is true and correct to the best of my knowledge; ii) That I have read and understood QIHE's <i>Health and Safety Policy</i> ; iii) That I may be required to provide additional information, supporting evidence, or participate in follow-up discussions to facilitate investigation and resolution of the incident; iv) That all personal information provided will be managed confidentially in accordance with QIHE's <i>Records Retention Policy</i> and the <i>Privacy Act 1988 (Cth)</i> , and may be shared with authorised regulatory or emergency bodies where required by law.			
Full Name			
Signature		Date	