

AUSTRALIAN AUTOMOTIVE GROUP – INCIDENT REPORT FORM

INCIDENT REPORT FORM

PART A – INJURED WORKERS DETAILS

Name Andrew Hillier Gender ☒ Male ☐ Female
Position title 2nd Yr App. Mechanic Date of Birth 19 Aug 1994
Site location employed at City Ford Rockdale Shift time 8am – 16:00pm

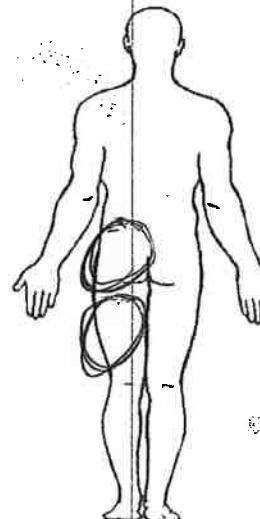
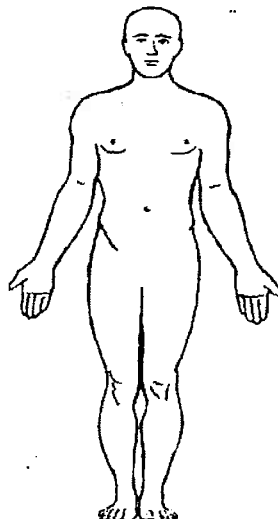
PART B – PERSON COMPLETING THIS FORM

Full Name Andrew John Hillier
Position App. Mechanic. 2nd Year
Relationship to the Employee _____
Time you reported this incident to your manager 1pm 29 Nov 2018

PART C – INCIDENT DETAILS

Where did the injury occur ☒ As above ☐ other (specify) _____
Date of injury 29 Nov 2018 Time of injury 8:30am
Full Name Andrew Hillier Contact No 040802454
Was there any witnesses ☒ No ☐ Yes (specify) _____
Contact No _____
Is photo evidence attached ☒ No ☐ Yes (specify) _____
Contact No _____
What training was completed ☐ None ☒ SOP ☐ Tool Box ☐ Site Induction ☐ AAG Induction ☐ Other (specify) _____

Please mark the location of where the injuries occurred. Please Take note of the left and right side of the body and add notes as required.



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PART D – INCIDENT TYPE - Please ensure all relevant categories are marked

- | | | |
|--|--|--|
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Electric shock | <input type="checkbox"/> Sound and pressure |
| <input type="checkbox"/> Serious lacerations | <input type="checkbox"/> Burn(s) | <input checked="" type="checkbox"/> Body Stressing |
| <input type="checkbox"/> Minor lacerations | <input type="checkbox"/> Manual Handling | <input type="checkbox"/> Bullying, Harassment |
| <input type="checkbox"/> Falls, Slips, Trips (from height) | <input type="checkbox"/> Hitting object with body part | <input type="checkbox"/> Mental Stress |
| <input type="checkbox"/> Falls, Slips, Trips (from same level) | <input type="checkbox"/> Hit by moving object | <input type="checkbox"/> Near Miss |
| <input type="checkbox"/> Fracture | <input type="checkbox"/> Chemical related | <input type="checkbox"/> Other |

PART E – REMEDY - Please ensure all relevant categories are marked

- | | | |
|--|--|--|
| <input type="checkbox"/> No First Aid Required | <input type="checkbox"/> Medical Treatment (Hospital) | <input type="checkbox"/> Fatality |
| <input type="checkbox"/> First Aid Required – No Doctor Required | <input checked="" type="checkbox"/> Medical Treatment (Medical Centre) | <input type="checkbox"/> N/A Near Miss |

PART F – ADDITIONAL MATTERS - Please ensure all relevant categories are marked

- | | | |
|---|---|--|
| <input type="checkbox"/> SWP was not followed | <input type="checkbox"/> Equipment was not sufficient | <input type="checkbox"/> N/A Near Miss |
| <input type="checkbox"/> There was improper supervision | <input type="checkbox"/> Equipment was damaged | <input checked="" type="checkbox"/> Other (please specify below) |
| <input type="checkbox"/> There was improper training | <input type="checkbox"/> Equipment was misused | <u>misplaced equipment</u> |

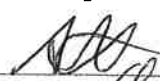
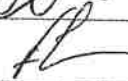
PART G – DESCRIPTION OF INCIDENT - Please ensure all relevant categories are marked

Removing hoist pad extension placed next to hoist structure. Stepped away from work space & applied pressure, straining on hoist extension. Extension has rolled from under left leg, causing back to twist.

PART H – IMMEDIATE ACTION TAKEN

Attended medical centre - advised of strain to lower left back. Prescribed medicines to solve.

PART I – ACKNOWLEDGEMENT

Full Name	Position	Signature	Date
Andrew Hillier	App. Jack		12-12-18
FRED JEANES	SERVICE MANAGER		12-12-18