

# AUSTRALIAN AUTOMOTIVE GROUP – INCIDENT REPORT FORM

## INCIDENT REPORT FORM

### PART A - INJURED WORKERS DETAILS

Name MARIAN VAN DER WEELEN Gender ☐ Male ☒ Female  
Position title SALE CONSULTANT - NEW CARS Date of Birth 05/12/59  
Site location employed at POWER FORD Shift time 8-30am

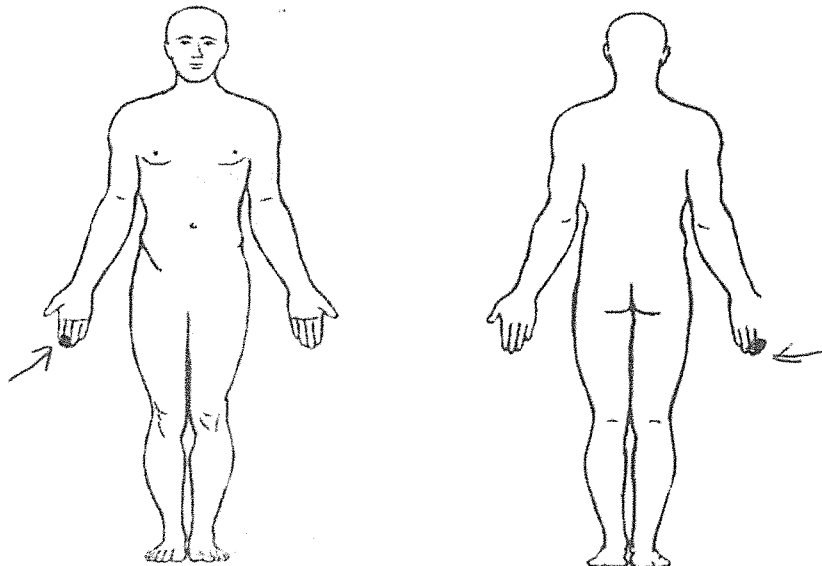
### PART B – PERSON COMPLETING THIS FORM

Full Name MARIAN VAN DER WEELEN  
Position SALES CONSULTANT - NEW CARS  
Relationship to the Employee SELF  
Time you reported this incident to your manager 8.40am

### PART C – INCIDENT DETAILS

Where did the injury occur ☒ as above ☐ other (specify)  
Date of injury 20<sup>th</sup> MARCH 2019 Time of injury 8-32am  
Full Name MARIAN VAN DER WEELEN Contact No 0432 122 000  
Was there any witnesses ☒ No ☐ Yes (specify)  
Contact No \_\_\_\_\_  
Contact No \_\_\_\_\_  
Is photo evidence attached ☐ No ☒ Yes (specify) FRONT + REAR PHOTOS OF TWO INJURED FINGERS  
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 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 checked="" 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 checked="" type="checkbox"/> First Aid Required – No Doctor Required | <input 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 type="checkbox"/> Other (please specify below) |
| <input type="checkbox"/> There was improper training    | <input type="checkbox"/> Equipment was misused        |   |

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

1ST + 2ND FINGERS JAMMED IN CAR DOOR

## PART H – IMMEDIATE ACTION TAKEN

ICE APPLIED, ELEVATED TO REDUCE THROBBING + SWELLING

## PART I – ACKNOWLEDGEMENT

Full Name

Position

Signature

Date