AUSTRALIAN AUTOMOTIVE GROUP – INCIDENT REPORT FORM

INCIDENT REPORT FORM

PART A - INJURED WORKERS DETAILS

Name: Simon Suleski

Gender: ☑ Male ☐ Female

Position title: Apprentice

Date of Birth: 20/12/97.

Site location employed at: Rockdale

Shift time: 8 – 4:06pm.

PART B – PERSON COMPLETING THIS FORM

Full Name: FRED JEANES

Position: Service manager

Relationship to the Employee: Manager.

Time you reported this incident to your manager: 11:30 am.

PART C – INCIDENT DETAILS

Where did the injury occur: ☑ as above ☐ other (specify)

Date of injury: 18-3-19.

Time of injury: 11:30 am.

Full Name: Simon Suleski

Contact No:

Was there any witnesses ☐ No ☑ Yes (specify): Matthew Walsh.

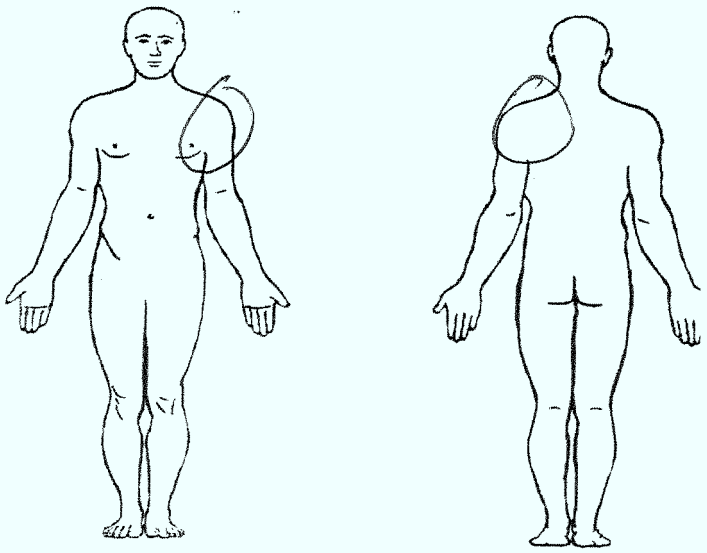
Contact No:

Contact No:

Is photo evidence attached: ☑ No ☐ Yes (specify)

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

☐ Amputation	☐ Electric shock	☐ Sound and pressure
☐ Serious lacerations	☐ Burn(s)	☑ Body Stressing
☐ Minor lacerations	☑ Manual Handling	☐ Bullying, Harassment
☐ Falls, Slips, Trips (from height)	☐ Hitting object with body part	☐ Mental Stress
☐ Falls, Slips, Trips (from same level)	☐ Hit by moving object	☐ Near Miss
☐ Fracture	☐ Chemical related	☐ Other

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

☐ No First Aid Required	☑ Medical Treatment (Hospital)	☐ Fatality
☐ First Aid Required – No Doctor Required	☐ Medical Treatment (Medical Centre)	☐ N/A Near Miss

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

☐ SWP was not followed	☐ Equipment was not sufficient	☐ N/A Near Miss
☐ There was improper supervision	☐ Equipment was damaged	☐ Other (please specify below)
☐ There was improper training	☐ Equipment was misused	_____

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

Simon was refitting a wheel & tyre to a vehicle on the hoist, the tyre fell of & Simons natural reaction was to try & catch it resulting in a dislocation of his left shoulder

PART H – IMMEDIATE ACTION TAKEN

Taken to hospital

PART I - ACKNOWLEDGEMENT

Full Name	Position	Signature	Date
Fred Seares	Manager		13/3/19

Certificate of capacity/ certificate of fitness

NSW GOVERNMENT | State Insurance Regulatory Authority

For use with workers compensation and Compulsory Third Party (CTP) motor accident injury claims.

☐ CTP ☐ Workers compensation

For CTP claims: 'Certificate of fitness' means 'certificate of fitness for work'. This certificate should be completed whether the person was employed at the time of the accident or not.

☐ Tick if this is the initial certificate for this claim.

Section 1: To be completed by the injured person or treating medical practitioner

First name: Simon

Last name: Sulesiki

Date of birth (DD/MM/YYYY): 20/12/1997

Telephone number: 0427693363

Address (must be residential address – not PO Box): 76 princes high way

Suburb: albion park rail

State: NSW

Postcode: 2527

Claim number:

Medicare number: 2493170428

Occupation/job title: mechanic

Employer's name and contact details (if applicable): 85774694 city ford Rockdale

Injured person's consent

I consent to my treating medical practitioner, my employer (optional for CTP claims), the insurer, other medical practitioners or health related practitioners (whether consulting, treating or examining), workplace rehabilitation providers and SIRA exchanging information for the purpose of managing my injury and workers compensation/motor accident injury claim.

I understand this information will be used by SIRA and insurers to fulfill their functions under the motor accident insurance and workers compensation legislation.

Signature: S Sulesiki

Date (DD/MM/YYYY): 18/03/2019

Section 2: To be completed by treating medical practitioner

Medical certification

Diagnosis of work related injury/disease or motor accident related injury(ies): Soft tissue injury to (L) shoulder region + (R) hand pain

Person's stated date of injury/accident (DD/MM/YYYY): 18/3/2019

Shaded areas to be completed for initial certificate only

Person was first seen at this practice/hospital for this injury on (DD/MM/YYYY): 18/3/2019

Injury is consistent with person's description of cause: ☒ Yes ☐ No ☐ Uncertain

How is the injury related to work or the motor vehicle accident?

working as a mechanic

Detail any pre-existing factors which may be relevant to this condition or injury(ies)

nil

First name: Simon | Last name: Suleski | Claim number:

Management plan for this period

Treatment/medication type and duration

Xray to exclude fracture / dislocation, arm sling, ice and resting, oral analgesia

Referral to another health service or rehabilitation provider (include details of provider type and service requested, duration and frequency when relevant)

GP to review L shoulder within 72 hours and possibly arrange Ultrasound to exclude ligament injury

Capacity for activities – If the person has capacity for pre-injury work this section does not need to be completed. For all others please consider activities of daily living currently being performed.

Lifting/carrying capacity

Sitting tolerance

Standing tolerance

Pushing/pulling ability

Bending/twisting/squatting ability

Driving ability

Other (please specify) eg psychological considerations, keep wound clean and dry

Next review date (DD/MM/YYYY) 20/3/2019 (if greater than 28 days, please provide clinical reasoning)

Comments

GP review

Capacity for work (please consider the health benefits of good work when completing this section).

Where the word 'capacity' appears below it should be read as 'fitness for work' when the certificate is completed in a motor accident injury claim.

Do you require a copy of the position description/work duties? ☐ Yes ☐ No

☐ is fit for pre-injury work from — Date (DD/MM/YYYY)

☐ has capacity for some type of work from ____ to ____ for ____ hours/day ____ days/week

☒ has no current capacity for any work from 18/3/19 to 20/3/19

If no current capacity for work, estimated time to return to any type of employment

Factors affecting recovery

First name: Simon | Last name: Suleski | Claim number:

Treating medical practitioner details

I certify that I am the treating medical practitioner and I have examined this person. The information and medical opinions contained in this certificate are, to the best of my knowledge, true and correct.

Signature: [signature] | Date (DD/MM/YYYY): 18/2/2019

Name: Trevr Chan

Address: St George Hospital Emergency Gray St Kogarah 2217

Suburb: Kogarah | State: NSW | Postcode: 2217

Telephone number: (02) 9113 1111 | Provider number: 2088275Y

☐ I agree to be the nominated treating doctor for the ongoing management of this person's injury, treatment and recovery at/return to work (tick if you consent).

Section 3: Employment declaration (not to be completed by the treating medical practitioner)

This section is to be completed by the person prior to sending to the insurer (or employer).

First name | Last name

☐ I have ☐ I have not (tick appropriate box)

engaged in any form of paid employment, self employment or voluntary work for which I have received or am entitled to receive payment in money or otherwise since the last certificate was provided, that I have not yet declared to the insurer.

If so, please provide details below.

I declare that the details I have given on this declaration are true and correct, knowing that false declarations are punishable by law.

Signature | Date (DD/MM/YYYY)

Catalogue No. SIRA08719
State Insurance Regulatory Authority, 92-100 Donnison Street, Gosford, NSW 2250
Locked Bag 2906, Lisarow, NSW 2252 | Customer Experience 13 10 50
Website www.sira.nsw.gov.au

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