

AUSTRALIAN AUTOMOTIVE GROUP – INCIDENT REPORT FORM

INCIDENT REPORT FORM

PART A - INJURED WORKERS DETAILS

Name John Paul ~~Jack~~ O'Donoghue Gender ☒ Male ☐ Female
Position title 2nd Year Apprentice Date of Birth 16/11/2000
Site location employed at Beard Karlick Ford Shift time 9:30 am

PART B – PERSON COMPLETING THIS FORM

Full Name John Paul O'Donoghue
Position 2nd Year Apprentice
Relationship to the Employee _____
Time you reported this incident to your manager 9:30 am

PART C – INCIDENT DETAILS

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

Date of injury 14/6/19 Time of injury 9:30 am

Full Name John Paul O'Donoghue Contact No 04811 37755

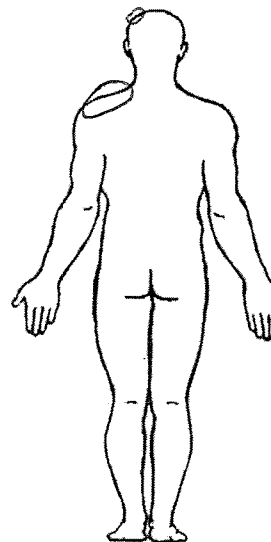
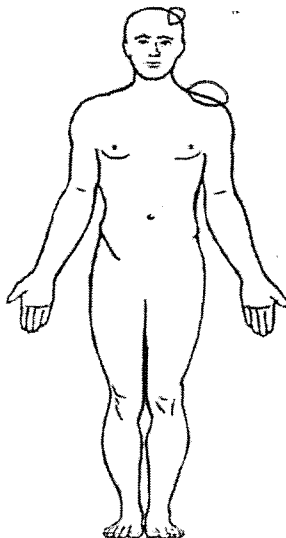
Was there any witnesses Ryan Myers Contact No _____
☐ No ☒ Yes (specify)

Vince Tropiano 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

- | | | |
|---|--|---|
| <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 type="checkbox"/> Hitting object with body part | <input type="checkbox"/> Mental Stress |
| <input checked="" 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 checked="" type="checkbox"/> Medical Treatment (Hospital) | <input type="checkbox"/> Fatality |
| <input 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

Walking to get water bottle, ~~Fell~~ Felt dizzy and light headed, woke up on the ground. With sore shoulder and head.

PART H – IMMEDIATE ACTION TAKEN

Manager was called, employee was taken to hospital for ~~a full~~ check up

PART I - ACKNOWLEDGEMENT

Full Name	Position	Signature	Date