

# AUSTRALIAN AUTOMOTIVE GROUP – INCIDENT REPORT FORM

## INCIDENT REPORT FORM

### PART A - INJURED WORKERS DETAILS

Name BOB MITREVSKI

Gender ☒ Male ☐ Female

Position title MOTOR MECHANIC

Date of Birth 29/8/61

Site location employed at CHULLORA

Shift time FULL TIME

### PART B – PERSON COMPLETING THIS FORM

Full Name BOB MITREVSKI

Position MOTOR MECHANIC

Relationship to the

Employee

SELF

Time you reported this  
incident to your manager

FRIDAY 9/8/19 - 2pm Approx.

### PART C – INCIDENT DETAILS

Where did the injury occur ☒ as above ☐ other (specify) CITY FORD WORK SHOP CHULLORA

Date of injury 9/8/19

Time of injury 2pm.

Full Name BOB MITREVSKI

Contact No 0417671406

Was there any witnesses

☒ No ☐ Yes (specify)

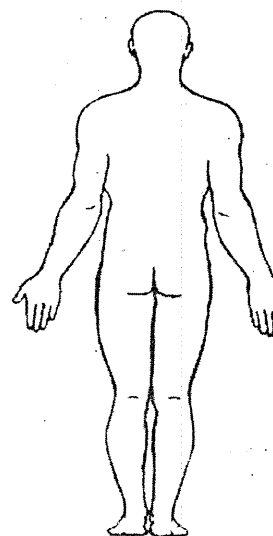
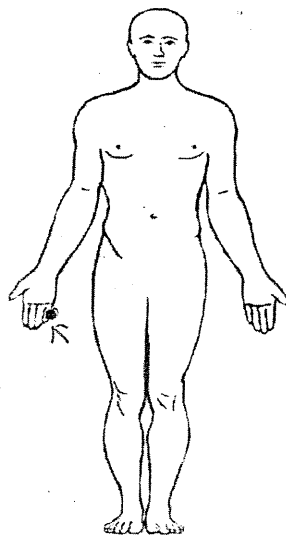
Contact No

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

- |  |  |   |
|--|--|---|
| <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 type="checkbox"/> Falls, Slips, Trips (from same level) | <input type="checkbox"/> Hit by moving object          | <input type="checkbox"/> Near Miss            |
| <input checked="" 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 checked="" type="checkbox"/> Other (please specify below) |
| <input type="checkbox"/> There was improper training    | <input type="checkbox"/> Equipment was misused        | FRACTURED RIGHT LITTLE FINGER                                    |

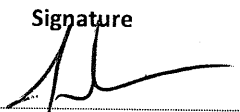
## PART G – DESCRIPTION OF INCIDENT - Please ensure all relevant categories are marked

Whilst installing & pushing the Heavy battery into place I twisted my Right hand little finger against the battery.

## PART H – IMMEDIATE ACTION TAKEN

It swelled up, I applied an ice pack on it & reported it to John Vernon. my finger is still sore & I will see my doctor.

## PART I - ACKNOWLEDGEMENT

Full Name	Position	Signature	Date
JON VERNON	SALES MANAGER		13/08/19.