# WORKPLACE INCIDENT AND ACCIDENT REPORT

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| **Reporting Officer’s Name** | **Signature** | |
|  |  | |
| **Location of Workplace Premises** | | **Date** |
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| **Incident/Accident Record** | | | | | | | | |
| **Type of Incident (check relevant box)** | | | | | | | | |
| Injury | Equipment Damage | | Threat | | Critical event | | Near miss | Abuse |
| **Person or Persons Involved (check relevant box or boxes)** | | | | | | | | |
| Employee/Vol | | Client/Carer/Family | | Visitor/Public | | Emergency Services | | Police |

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| --- | --- | --- | --- |
| **Personal Data (complete for each person involved)** | | | |
| **Full Name (Person 1)** | | **Full Residential Address** | |
|  | |  | |
| **Date of Birth** | **Gender** | **Occupation Title** | **Employment Status** |
|  |  |  |  |
| **Full Name (Person 2)** | | **Full Residential Address** | |
|  | |  | |
| **Date of Birth** | **Gender** | **Occupation Title** | **Employment Status** |
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Was First Aid required? Yes No

Was Medical treatment required? Yes No

Is a Workers’ Compensation Claim anticipated? Yes No

Is this a Mandatory Reporting incident? Yes No

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| --- | --- | --- |
| **Contact Details of Witnesses** | | |
| **Name** | **Full Residential Address** | **Contact Phone** |
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| **Investigations** | | |
| **Time of Incident:**  HH/MM | **Date of Incident:**  DD/MM/YY | **Place of Incident:** |
| **Enter a detailed description of the incident/injury** | | |
|  | | |
| **Enter a description of the work/task being performed at the time** | | |
|  | | |
| **Describe how or why the event occurred, including likely or known causes** | | |
|  | | |
| **Corrective/Preventive Actions** | | |
| **Describe any immediate remedial/corrective action taken** | | |
|  | | |
| **Describe any recommended preventive actions/improvement plans to prevent recurrence of the event** | | |
|  | | |

### Report Distribution

Original Copy of this Report is to be given to the designated Safety Officer.

One Copy of this Report is to be forwarded to the Management for analysis and improvement planning.