# Incident Report

This section is to be completed by the supervisor | No Lost Time ☐ | Lost Time ☐ | Near Miss ☐ | Report Number: -

**Notification by Worker**

**NOTE: If there is insufficient space below, please attach additional information.**

Family Name: .................... Given Name(s): ....................

Description of Incident: -

Incident Location: ....................

Time and Date of Incident: ...... : ...... am pm ...... / / ......

**Witnesses:**

Name: .................... Address: ....................

Name: .................... Address: ....................

**Did the Accident Occur:**

At worksite ☐ Vehicle incident while working ☐ During break ☐ Journey to or from work ☐

| Part of Body | | Incident Type | |
|---|---|---|---|
| ☐ No injury sustained | ☐ Arm | ☐ Trip/Fall | ☐ Harmful Contact/Exposure |
| ☐ Head | ☐ Hand/Wrist | ☐ Falling Object | ☐ Vehicle/Plant work |
| ☐ Eye | ☐ Leg | ☐ Caught in | ☐ Recurrence |
| ☐ Neck | ☐ Foot/Ankle | ☐ Struck by | ☐ Stress / Anxiety |
| ☐ Trunk - front | ☐ Internal | ☐ Manual Handling | |
| ☐ Trunk - back | ☐ Multiple | ☐ Repetitive Work | |
| Other .......... | | Other .......... | |

**Signature:** (Injured person) .................... Date: / /

Name of person who completed the report if not the injured person.

**Supervisor's Report**

**Notifiable Occurrence** (Refer Incident Reporting & Investigation Procedure)

Has this incident resulted in a notifiable occurrence? Yes ☐ No ☐ **X** where applicable

**If "Yes" the incident must be reported to SafeWork SA by the nominated person in consultation with the AAB Chair.**

Date reported: / / By whom *(print name)*: ....................

| Treatment | | | Outcome |
|---|---|---|---|
| ☐ Nil | ☐ First Aid | ☐ Doctor | ☐ Returned to Work i.e. **No lost time other than for First Aid or examination by a Doctor.** |
| ☐ Ambulance | ☐ Hospital | | Date and time if work ceased / / : am pm |

Is this a Worker's Compensation claim? Yes ☐ No ☐ If "Yes" the employee must complete a Worker Report & Kit

Claim Form Received / /

Date Employer and Claim forms forwarded to HR / /

**A copy of this form must be forwarded to the following people: -**

BIGG Chair ☐ Date Forwarded / / Name:

AAB Chair ☐ Date Forwarded / / Name: ....................

Report sighted by supervisor .................... Date / /

**Please complete the section at the top of this form. A Report Number will be assigned to this form.**

**NOTE: If there is insufficient space below, please attach additional information.**

## Investigation

Name and position of person responsible for investigation: ............................ ............................

Date expected to be completed: ......../......../........

**List all contributing factors below** Please check the box (X) when a factor is considered essential

A contributing factor is an event or situation that occurred or existed at any time prior to the incident.
Essential factors are those contributing factors that had they not been present the incident would not have occurred.

| Contributing factor | Essential |
|---|---|
| | ☐ |
| | ☐ |
| | ☐ |
| | ☐ |
| | ☐ |
| | ☐ |
| | ☐ |
| | ☐ |
| | ☐ |
| | ☐ |

## Corrective and Preventative Action

Name and position of person responsible for action: ............................ ............................

Date expected to be completed: ......../......../........ Please rate the hazard High, Medium or Low (H, M, L). ☐

**Corrective Actions (Short Term)**

Description of Action(s): -

**Preventative Actions (Long Term)**

**Control Method *** Elimination ☐ Substitution ☐ Engineering ☐ Administrative ☐ PPE ☐

Description of Action(s): -

**Confirmation of Completed Action**

Signature of person responsible for actioning the report ............................ Action complete (date) ......../......../........

**Supervisor Sign Off**

Supervisor (signature) ............................ Date: ......../......../........

**When completed this form is to be forwarded to AAB Chair.**