Which of the following are you reporting? (Tick more than one if appropriate).

[ ]  Personal Injury [ ]  Complaint [ ]  Security [ ]  Equipment Malfunction

[ ]  Near Miss [ ]  On-going Condition [ ]  Property Damage [ ]  Venue Alarm

[ ]  Fatality [ ]  Reported Hazard [ ]  Environmental Damage [ ]  Other

| **Venue:**  |  |
| --- | --- |
| **Details of Employee Filling in this Form:** |
| Surname:  | First Name: | Department:  |
| Position Title:  | Work Ph:  | Home Ph: |
| Date and approximate time of Incident: | Date:  | Time:  |
| Date and approximate time of Report: | Date:  | Time:  |

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| **Details of affected or involved individual(s):** *(Please circle category below, circle more than one box if appropriate).* |
| Venue Staff(s) | Contractor(s) or Sub- Contractor(s) | External Hirer Staff(s) | Performer(s) | Volunteer(s) | Patron(s), Visitor(s) or General Public |
| Surname: | First Name: | Department: |
| Position Title: | Work Ph:  | Home Ph: |
| Date of Birth: | Gender: [ ]  Male [ ]  Female | Pre-Existing Medical Condition?[ ]  Yes [ ]  No [ ]  Unknown |
| Address: |
| Status at Time of Incident: [ ]  On Duty at Workplace (Commenced at: Hrs.) [ ]  Visiting Workplace [ ]  Other [ ]  Travelling whilst on Duty [ ]  Visiting Venue [ ]  Travelling to or from Workplace [ ]  Attending Event or Performance  |
| Individual ceased work before end of shift [ ]  Yes [ ]  No [ ]  Unknown | If Yes, approx time: Hrs.  |

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| **Details of Witness(s):** (Please circle category below, circle more than one box if appropriate).  |
| Venue Staff(s) | Contractor(s) or Sub- Contractor(s) | External Hirer Staff(s) | Performer(s) | Volunteer(s) | Patron(s), Visitor(s) or General Public |
| Surname:  | First Name:  | Department:  |
| Position Title:  | Work Ph: - | Home Ph: |
| **Date of Birth:** | Gender**: [ ]** Male **[ ]** Female | Witness provided evidence in writing?[ ]  Yes [ ]  No  |
| Address: |

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| **Incident Evidence or Record:** Is there any record of the incident? (tick more than one box if appropriate). |
| **[ ]** Witness [ ]  Photos [ ]  CCTV [ ]  Written Statement [ ]  Other [ ]  None |

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| **Type of Incident:** |
| [ ]  Fall from Height [ ]  Fall on the Same Level (including slips, trips and falls)[ ]  Hitting objects with a Part of the Body[ ]  Exposure to Mechanical Vibration[ ]  Being Hit by Moving Objects[ ]  Exposure to Sudden Sharp Sound[ ]  Long term Exposure to Sound[ ]  Exposure to Variations in Pressure (other than sound)[ ]  Repetitive Movement with Low Muscle Loading[ ]  Other Muscular Stress[ ]  Contact with Electricity | [ ]  Contact or Exposure to heat and cold [ ]  Exposure to Radiation [ ]  Single Contact with Chemical or Substance [ ]  Long Term Contact with Chemical or Substance [ ]  Other Contact with Chemical or Substance [ ]  Insect bites and stings[ ]  Contact with, or Exposure to, Biological Factors[ ]  Exposure to Mental Stress Factors[ ]  Vehicle Accident[ ]  Other and or Multiple Mechanisms of Injury[ ]  Unspecified Mechanisms of Injury  |

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| **Description of Incident** |
|  |
| **Immediate Corrective Actions** |
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| Equipment Damaged: [ ]  Yes [ ]  No [ ]  Unknown |
| Equipment/ Plant Type: | Description of Damage:  |
| Has the Equipment or Plant Involved been Isolated for Inspection? [ ]  Yes [ ]  No [ ]  Unknown |
| If Yes, Provide Details: |
| Chemical Involved:  | [ ]  Yes [ ]  No [ ]  Unknown | Type:  |
| Description of Damage:  |
| Property Involved:  | [ ]  Yes [ ]  No [ ]  Unknown | Property Damaged: [ ]  Yes [ ]  No [ ]  Unknown |
| PropertyType: | Description of Damage: |
| Environmental Impact:  | [ ]  Yes [ ]  No [ ]  Unknown | Impact Description:  |
| Exact Location of Incident:  |
| Weather Conditions (if aplicable): |
| Emergency Services Attended: [ ]  Yes [ ]  No [ ]  Unknown [ ]  N/A |
| Which Service: [ ]  Police [ ]  Ambulance [ ]  Fire Service [ ]  Unknown |
| Case Number (if Police): | Officers who Attended: |

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| **Location of Injury(s) or illness(s):** *(Please tick category below).* |
| [ ]  Eye(s) (Left/ Right)[ ]  Ear(s) (Left/ Right)[ ]  Face[ ]  Head (other than eye, ear or face)[ ]  Neck[ ]  Back[ ]  Trunk (other than back and excluding internal organs) | [ ]  Shoulders and Arms (Left/ Right)[ ]  Hands and Fingers (Left/ Right)[ ]  Hips and Legs (Left/ Right)[ ]  Feet and Toes (Left/ Right)[ ]  Internal organs (located in the trunk)[ ]  Multiple Locations (more than one of the above)[ ]  General and Unspecified Location(s) |
| **Show location of injury below** |
| Image result for human body |
| **Onset of Symptoms:** *(Please tick category below).* |
| **[ ]**  At Time of Incident [ ]  Later – Approximate Time: [ ]  Re-occurring Symptoms  |
| **Provide Descriprtion of Injury or Illness:** |
|  |
| **Medical Treatment Administered by:**  |
| **Name: Time:**  |
| **Type of Medical Treatment Administered:** *(Please tick category below, tick more than one box if appropriate).* |
| [ ]  No Treatment Given[ ]  Self-Administered First Aid [ ]  First Aid Administered by Venue Staff [ ]  Treatment by Paramedical Officer/ Emergency Services Personnel  | [ ]  Treatment by General Practitioner (GP)[ ]  Treatment by Emergency Department Personnel[ ]  Treatment by Medical Specialist[ ]  Unknown |
| **Provide Descriprtion of Medical Treatment**  |
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| **Employee Certification:** |
| *I Agree the Information is a True and Accurate Record of the Situation.* |
| **Employee Completing Report:** *(Please Print Name Below)*  | **Signature:** *(Please Sign Name Below)*  | Date Signed:  |
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| Incident Investigation |
| Has the Incident Been Investigated? **[ ]**  Yes **[ ]**  No |
| Reason for not Investigating? |
| **Follow Up Corrective Action** |
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| --- | --- | --- |
| **Management Completing Report:** *(Print Name Below)*  | **Manager Position Title:** | **Date Signed:** |
|  |  |  |
| **Signature:** *(Please Sign Name Below)*  | **Contact Details:** |
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