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: |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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. | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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**:** MaleFemale | | Witness provided evidence in writing?  Yes  No | |
| Address: | | | | | |

|  |
| --- |
| **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 |

|  |  |
| --- | --- |
| **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 |

|  |
| --- |
| **Description of Incident** |
|  |
| **Immediate Corrective Actions** |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| 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: |

|  |  |  |
| --- | --- | --- |
| **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** | | |
|  | | |

|  |  |  |
| --- | --- | --- |
| **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: |
|  |  |  |

|  |
| --- |
| Incident Investigation |
| Has the Incident Been Investigated?  Yes  No |
| Reason for not Investigating? |
| **Follow Up Corrective Action** |
|  |

|  |  |  |
| --- | --- | --- |
| **Management Completing Report:** *(Print Name Below)* | **Manager Position Title:** | **Date Signed:** |
|  |  |  |
| **Signature:** *(Please Sign Name Below)* | **Contact Details:** | |
|  |  | |