

Accident/ Hazard/ Incident Report

Use this form to report any workplace accident, injury, illness, near miss, dangerous occurrence or hazard. A separate Workers Compensation Claim Form and Certificate of Capacity is required if compensation is sought. A copy of this form should be retained by you. The form should be reviewed and signed by your supervisor. Original copy must then be forwarded to the Operations Manager

Details of the person involved in the accident / incident or reporting the hazard

Surname: _____ Given Names: _____ Date of Birth: _____ Sex: M F

Status: Staff: Sessional Staff: Student: Volunteer: Visitor/Other:

If staff: Location: _____ Job Title: _____

All other: Name: _____ Address: _____

Contact Number: _____

Details of the accident / hazard / incident

Date of accident: _____ and Time: _____ am/pm Location: _____

Where did the event happen? Be specific, e.g. room and building _____

Describe the **accident**: task being performed, sequence of events, unexpected event, or **hazard**: the nature and seriousness of the hazard or the **incident**: sequence of events, unexpected event

Witness (if any) _____

Details of the injury / illness if any

Type(s) of injury/illness e.g. strain, cut , burn

Part(s) of the body injured: specify left/right where appropriate

Injury event: what action/exposure/event directly caused the injury/illness. Injury agent: What object/substance/circumstances were directly involved

Please Note, if applicable, Cause(s) of Accident/Hazard:

Human Error <input type="checkbox"/>	Maintenance Failure <input type="checkbox"/>	Poor Design <input type="checkbox"/>	Procedures Not Adequate <input type="checkbox"/>	Procedures Not Followed <input type="checkbox"/>	Random Event <input type="checkbox"/>	Training Not Adequate <input type="checkbox"/>	Sport Activity <input type="checkbox"/>
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Other: Please specify: _____

Actions recommended / taken to prevent re-occurrence or remove hazard:

Replace or repair equipment/area <input type="checkbox"/>	Improve Design <input type="checkbox"/>	Clean up <input type="checkbox"/>	Use safer alternative materials <input type="checkbox"/>	Provide training <input type="checkbox"/>	No action necessary <input type="checkbox"/>
Improve signage or markings <input type="checkbox"/>	Consult with workers <input type="checkbox"/>	Establish safe working procedure <input type="checkbox"/>	Improve or increase supervision <input type="checkbox"/>	Install safety devices <input type="checkbox"/>	Other Provide Details <input type="checkbox"/>

Action taken to prevent re-occurrence / remove hazard (and who by/when by?):

Supervisor: _____
_____ Date: _____ Extension: _____

Initial Treatment: None First Aider Doctor/hospital Other _____

Outcome: Returned to work/study? Yes No Admitted to hospital? Yes No

Name of the person completing this form

Name: _____ Date: _____