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 ☐	Maintenance Failure ☐	Poor Design ☐	Procedures Not Adequate ☐	Procedures Not Followed ☐	Random Event ☐	Training Not Adequate ☐	Sport Activity ☐

Other: Please specify: _____

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

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

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: _____