

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 Community Services Coordinator.

Services Coordinator.	
Details of the person involved in the accident / incident or reporting the hazard	
Surname:	
Status: Staff: Sessional Staff: Student: Volunteer: 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 <u>accident</u> : task being performed, sequence of events, unexpected event, or <u>hazard</u> : the nature and seriousness of the hazard or the <u>incidented</u> sequence of events, unexpected event	<u>ent</u> :
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	
Places Note if applicable Cause(a) of Assident/Herord	
Please Note, if applicable, Cause(s) of Accident/Hazard: Human	7
Error L-J Failure L-J Design L-J Adequate L-J Not Followed L-J Event L-J Adequate L-J Activity L- 	
Other: Please specify:	
Actions recommended / taken to prevent re-occurrence or remove hazard:	
Replace or repair provide training provi]
Improve signage or markings Consult with workers Establish safe working procedure Working procedure Improve or increase supervision Install safety devices Other Provide]
Action taken to prevent re-occurrence / remove hazard (and who by/when by?):	
Superv	visor
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:	
Name. Date.	