**INCIDENT / INJURY/ NEAR MISS REPORT**

*To be completed for* ***ALL*** *incidents, injuries, accidents* ***and*** *near misses\**

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| **Regarding: (Please tick who this report is about)**  | **Date (of report completion):** |
| Client 🞏 Employee 🞏 Family/Carer 🞏 Visitor 🞏 Contractor 🞏 Volunteer 🞏 Other 🞏  |
| **1. Details of person involved in incident:** |
| Surname: | Phone:  |
| First Name: | Sex: Male 🞏 Female 🞏 Other 🞏 Unknown 🞏 |
| Address: | Date of Birth: |
|  | 1st Language: |
| **2. Details of witnesses (if any):** |
| 1) Name: | Contact information e.g. phone, house number, address etc. |
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| 2) Name: | Contact information e.g. phone, house number, address etc. |
| **3. Details of incident or accident:** |
| Date: | Time of injury: |
| Activity engaged in: |
| Location of incident / accident: |
| Describe how and what happened: *(please give full details & include a diagram, if appropriate. Use a separate sheet if necessary.* *Please include car registration number if reporting a Motor Vehicle Accident)*: |
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\* A **near miss** is an unplanned event that did not result in injury, illness, or damage – but had the potential to do so.
A report of a near miss (close call) creates an opportunity for identifying and removing hazardous conditions and work practices and preventing accidents.

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| **4. Details of injury**  |
| Nature of any resulting injury / illness (e.g. burn, sprain, cut etc): |
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| How the injury was sustained (e.g. fall, grabbed by a person etc.): |
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| Location on body (e.g. back, right thumb, left arm etc) indicate where injury by shading in affected area | Written description of the impact of the incident, including any injuries or psychological impacts. |
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| **5. Treatment administered:** |
| Did the person/s need medical assistance? Yes 🞏 No 🞏 If yes – where did they go and who was the Medical provider? |
| First Aid Administered: Yes 🞏 No 🞏  | By who? (Print Name): Signature:  |
| Treatment (summary if relevant) |
| Referred to another service e.g. Clinic, General Practitioner, Hospital: |

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| This page to be completed by the Senior Staff member |
| **6. Did the injured person stop work:** |
| Yes No If yes, state date: Time:Outcome: Treated by Doctor Lodged Workers Comp Claim Returned to alternative duties  Worksafe Authority notified Returned to normal duties  |
| **7. Incident or accident investigation** |
| (*Comments to include what caused or led to the accident/incident or near miss):* |
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| Name & Signature of Coordinator: Date: |
| **8. Remedial actions (tick all that are applicable):** |
| 🞏 | Document in the incident register and on hazard log.  | 🞏 | Investigate safer alternatives | 🞏 | Improve communication / reporting procedures |
| 🞏 | Conduct task analysis & develop/review tasks/procedures | 🞏 | Improve personal protection | 🞏 | Improve security |
| 🞏 | Improve or make changes to the work environment. | 🞏 | Improve design / construction / guarding | 🞏 | Temporarily relocate employees involved |
| 🞏 | Review WHS policy/programs | 🞏 | Provide debriefing and/or counselling | 🞏 | Request Falls Prevention Assessment |
| 🞏 | Replace equipment / tools | 🞏 | Re-train staff involved | 🞏 | Request MSDS (Materials Safety Data Sheet) |
| 🞏 | Request maintenance | 🞏 | Develop and/or provide training | 🞏 | Other (specify) |
| What, in your own words, has been implemented or planned to prevent recurrence: |
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| **9. Remedial actions completed:** |
| Signed: Title: Date: |