

Instructions: this form must be completed for an incident involving **injury** or **illness**, or for reporting a **workplace hazard** or **near miss** involving property or the work environment. Incidents involving actual or potential significant injury or illness must be immediately reported to the line manager (form is still needed). **Reports are recorded in a College Injury Register.**

Office Use
Report No:

PERSON COMPLETING THIS FORM: ☐ Injured Person ☐ Employee ☐ First Aid Officer ☐ Other / Manager (Please specify:.....)

Your First Name(s): Surname:

Email:@.....

Position/Job Title: Contact Phone No.:

INCIDENT TYPE: What type of incident are you reporting (Select / circle one only?) Injury Illness Hazard Near Miss

Was there any Property Damage Environmental Damage Unintentional (specify):.....

If you selected any of the above line property damage options please provide a brief description of the damage.

Property/Environmental Damage Details:

Property Damage Reported to Management on Date:/...../..... Name of Manager:

INJURED / ILL PERSON DETAILS:

Family name of injured person: Given name(s):

Staff Position:or Student No and Program of Study:.....DOB:/...../..... Gender: M or F (circle)

Address (Home): Postcode:

Phone (Work): (Home): (Mobile):

Work Location (e.g. Campus/Faculty/School/Division/Org. Unit):

If employee, what is their supervisor 's name: Phone:

Employment Status: Permanent Fixed Term Casual Contractor Full-Time Part-time Student Visitor Other:

DESCRIPTION OF INCIDENT / HAZARD / NEAR MISS

.....
.....
.....

REPORT TO BE SENT TO THE FOLLOWING SUPERVISOR / MANAGER:

Supervisor Name: Phone No:

INCIDENT / HAZARD / NEAR MISS DETAILS

Date of Incident/Hazard/Near Miss:/...../..... Time it Occurred: AM/PM Date Reported:/...../.....

Reported to: Location (Campus):

Building: Room No.:

Specific Location (addit, detail on location)

INJURY / ILLNESS DETAILS

Injury Type: ☐ Lost Time Date Stopped:/...../..... Time StoppedAM/PM

Treatment Type: ☐ Medical Treatment ☐ Hospital ☐ First Aid ☐ Ambulance Called

(Select all applicable) ☐ Intend to Seek Medical Treatment ☐ WorkCover ☐ Medical Certificate Issued ☐ No Treatment Required

Description of Treatment Provided:

Treatment Provided By: Phone No:

Description of Injury/Illness:

Task being Undertaken at time of Injury/Illness:

What Part of the Body was Injured:

WITNESS DETAILS (If applicable)

Name: Phone No:

Address:

CORRECTIVE ACTIONS

This section is to be completed by the supervisor receiving this report (supervisor nominated on page 1 of this form):

WHAT HAPPENED? (Immediate Cause)**Possible Contributing Factors (Basic Cause)**

Select all that apply:

- ☐ Lack of Knowledge (Training)
- ☐ Employee Placement
- ☐ Not Enforcing Safe Work Practices
- ☐ Engineering
- ☐ Inadequate Personal Protective Equipment (PPE)
- ☐ Inadequate Maintenance Programs
- ☐ Purchasing Inadequate/Inferior Equipment
- ☐ Inadequate Feedback Systems
- ☐ Unsafe Method

RECOMMENDED CORRECTIVE ACTION PLAN

For each Basic Cause identified under Possible Contribution Factors above you must provide a recommended corrective action.

Basic Cause	Corrective Action Description	Person Responsible	Target Completion Date

RISK ASSESSMENT

		CONSEQUENCES			
		1	2	3	4
LIKELIHOOD	A	H	H	H	M
	B	H	H	M	M
	C	H	M	M	L
	D	M	M	L	L

Risk Score: Enter H, M or L

Consequences

Consider what did or could have happened

- 1 = Death and extensive injuries
 2 = Medical treatment
 3 = First aid treatment
 4 = No treatment

Likelihood

How likely could this happen again?

- A = Could occur in most circumstances
 B = Could occur at some time
 C = Could occur, but only rarely
 D = May occur, but probably never will

SUPERVISOR / MANAGER DETAILS

Name: Position:
 Email: Phone No:
 Completed form **forwarded to CEO**, Tuggerah Lakes Community College on Date :