INCIDENT REPORT- Customer/Contractor

Incident report number: _____

Customers or Contractors shall use this form to report all work related injuries, illnesses, or "near miss" events (which could have caused an injury or illness) – no matter how minor. This helps us to identify and correct hazards before they cause serious injuries. This form shall be completed by the Customer or Contractor as soon as possible and given to a supervisor for further action.

PERSON/S AFFECTED

Name:_____

Address:_____

Date of birth:_____

Customer ☐ or Contactor ☐

Gender: male / female (please circle)

Phone number:_____

I am reporting a work related: ☐ Injury ☐ Illness ☐ Near miss

Have you told your supervisor about this injury/near miss? ☐ Yes ☐ No

Consequence of Incident (please circle)
Injury/ Fatality/ Medical treatment/ First Aid/ Lost time/ No Injury

Property damage (estimated) (please circle & add appropriate figures)
Building/ Plant/ Tools/ Other (please specify)_____ $_____.00

INCIDENT DETAILS

Date of Incident: / /

Time of incident:_____(am/pm)

Name of Witnesses (if any): _____

_____

_____

How did the incident occur? What was the person doing at the time? Describe step by step what led up to the injury/near miss(continue on the back if necessary)

_____

_____

_____

_____

Where did the incident occur? (Exact location e.g. reception, treatment room)

_____

_____

What action was taken?_____

_____

_____

Did anything in the environment contribute to the incident? (E.g. Floor, carpet, footwear/ clothing)_____

_____

_____

What could have been done to prevent this injury / near miss?

_____

_____

_____

What parts of your body were injured?

_____

Did you see a doctor about this injury/illness? ☐ Yes ☐ No

If yes, Doctor's Name: _____

Doctor's phone number: _____

Date: _____

Time: _____ (am/pm)

Has this part of your body been injured before? ☐ Yes ☐ No

If yes, when? _____

If a medical certificate has been provided please attach to this incident form.

Signature of Employee: _____ Date: _____

Name of attending supervisor: _____ Date: _____

Signature: _____

DRIVE & PASS
SPECIALISED DRIVER TRAINING

INCIDENT REPORT – Supervisor's Report

Name of Employee _____

Date of Birth _____

Telephone Number _____

Address _____

City _____ State_____ Post Code: _____

Job Position: _____

This employee works: ☐ Full time ☐ Part time ☐ Casual

Months with this employer: _____

Months doing this job: _____

What part of the body was injured? Describe in detail. _____
_____
_____

What was the nature of the injury? Describe in detail. _____
_____
_____
_____

Describe fully how the accident happened? What was employee doing prior to the event? What equipment, tools being using? _____
_____
_____
_____

Names of all witnesses: _____
_____
_____

Date of Event _____ Time of Event _____(am/pm)

Exact location of event: _____
What caused the event? _____
_____
_____

Were safety regulations in place and used? If not, what was wrong?

_____

_____

Describe, step-by-step the events that led up to the injury. Include names of any machines, parts, objects, tools, materials and other important details:

_____

_____

_____

_____

_____

_____

Employee went to doctor/hospital?

Doctor's Name _____

Hospital Name _____

Recommended preventive action to take in the future to prevent reoccurrence.

_____

_____

_____

_____

Has the employee lodged a Workers' Compensation Claim: ☐ YES ☐ NO

Has a Form 2B been completed: : ☐ YES ☐ NO

Date Form 2B and handbook provided to Employee: _____

Name of Supervisor: _____

Job Title: _____

Contact Number: _____

Supervisor Signature: _____

Date: _____

Incident Information- INCIDENT INVESTIGATION

Accident report number:_____

This report must be completed by the investigating supervisor within 24 hrs of an incident being reported. All relevant contact and incident information must be obtained from the person/s involved. A first aid report and any relevant information to the incident should be attached to this form where relevant.

Risk Assessment:

Consequence→ Likelihood↓	**Insignificant (1)** No injuries, low financial loss	**Minor (2)** First aid treatment, on-site hazard immediately contained, medium financial loss	**Moderate (3)** Medical treatment required, on-site hazard contained with outside assistance, high financial loss	**Major (4)** Extensive injuries, loss of production capability, off-site hazard with no detrimental effects, major financial loss	**Catastrophic (5)** Death, toxic hazard off site with detrimental effect, huge financial loss
A (almost certain)	H	H	E	E	E
B (Likely)	M	H	H	E	E
C (possible)	L	M	H	E	E
D (unlikely)	L	L	M	H	E
E (rare)	L	L	M	H	H

Summary Investigation:

_____

_____

_____

_____

_____

_____

Outcomes/action recommended:

_____

_____

_____

_____

_____

_____

Action Taken:

_____

_____

_____

_____

Date: _____

Signature of investigating supervisor:

Date: _____

Signature of Senior Manager:

Further review required? Y/N

Date for review: _____

Please attach all photographs, medical certificates, Form 2B when submitting this form.