

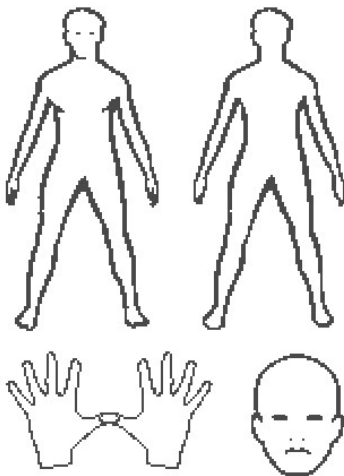
Accident and Incident Form

Section 1: Reporting and Accident or Incident

Company name:	Accident/incident type:
Address:	<input type="checkbox"/> Near-hit/near-miss <input type="checkbox"/> Injury <input type="checkbox"/> Illness
	Date of accident/incident:
	Time of accident/incident:
Name:	Job:
Address:	Length of time employed here:
	Phone:
	Date of birth:

Injury details - body part

Shade the part of the body that is injured



Injury Type (tick one)

- | | |
|--|---|
| <input type="checkbox"/> Aches/pain (gradual) | <input type="checkbox"/> Dermatitis |
| <input type="checkbox"/> Aches/pain (sudden) | <input type="checkbox"/> Dislocation |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Fatal |
| <input type="checkbox"/> Broken bone | <input type="checkbox"/> Foreign body |
| <input type="checkbox"/> Bruising incl. crushing | <input type="checkbox"/> Eye <input type="checkbox"/> Nose <input type="checkbox"/> Ear |
| <input type="checkbox"/> Burn/scald | <input type="checkbox"/> Inhalation disease (asbestos/lead) |
| <input type="checkbox"/> Chemical reaction | <input type="checkbox"/> Hearing loss (noise induced) |
| <input type="checkbox"/> Choking/suffocation | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> Concussion/brain injury | <input type="checkbox"/> Strain/sprain |
| <input type="checkbox"/> Cut (infected) | <input type="checkbox"/> Other |
| <input type="checkbox"/> Cut (not infected) | <input type="checkbox"/> Multiple injuries |
| <input type="checkbox"/> Dental injury | |

Treatment Details (tick)

- None
 First aid
 Nurse
 Physiotherapy
 Doctor
 Hospital

What happened and where did the event occur?

What do you think caused or contributed to the incident?

Section 2: Investigation of an Accident or Incident

Write down what you have found out about the injury/incident

List factors and hazards that contributed to the injury/incident

What action needs to be taken to prevent a similar incident/injury happening again?

Is this a serious harm injury?

Yes

No

If yes, report the injury to OSH as soon as possible, and on the prescribed form within seven days.

Investigation completed by:	
Name:	
Signed:	
Date:	

Adapted from ACC Worksafe Injury Incident Report Form and Injury Incident Investigation Form