Incident Report

Note: All sections of this form are to be completed. All incidents shall be advised within 12 hours of the incident to ensure appropriate action is initiated.

Personal details		
Family name:		First name:
Contact phone no:	(w)	(h - if injured)
☐Contractor ☐ EIA staff ☐ EIA student ☐ Visitor		Gender: ☐ M ☐ F
Division/Department/Course taken:		

Incident details		
Date of incident:	Time of incident:	AM / PM
Location where incident occurred:		
Briefly describe what happened:		
This incident resulted in: ❑ Injury ❑ No injury ❑ Near miss ❑ Property damage ❑ Hazard identified		
The incident was reported to (supervisor): Name of Supervisor: Date: _____		

Edvantage Institute Australia Pty. Ltd.
ABN: 32 617 256 818 CRICOS Code: TBA
TEQSA Provider Number: PRV14317

Injury/damage details
If an injury was sustained, what part of the body was affected or if damage to property occurred what was damaged?

Medical treatment		
If MEDICAL EXPENSES or LOST TIME is incurred, a '*Workers Compensation Claim form'* must be completed and forwarded to WHSW and IM Services 'as soon as possible'.		
Do you intend to seek medical treatment?	❑ Yes	❑ No
Do you intend to lodge a claim for workers compensation?	❑ Yes	❑ No
Has any time been lost from work? *(More than 1 complete shift)*	❑ Yes	❑ No
If so, have you returned to work?	❑ Yes	❑ No
Have/will medical expenses been incurred?	❑ Yes ❑ Uncertain at this time	❑ No
Were there witnesses? If so, name of witness(es):	Contact phone number:	
Employee signature:	Date:	

If a medical certificate has been provided please email: Welfare-Support@EIA.edu.au

Describe in detail what occurred
It is the responsibility of the supervisor/line manager to complete this section in consultation with the injured staff member.
Please describe the events and contributing factors that led to the incident:
How could this be prevented from happening again?
The Supervisor/Line Manager is to complete this section in consultation with the injured staff member and the health and safety representative (if applicable).
Suggestions to avoid recurrence of this incident/accident:
Name of health and safety representative, if consulted:

Report Reviewed by: _____Date: _____

Are there any further actions needed to be taken? **Yes / No** (If Yes, please describe below)