

## 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)
<input type="checkbox"/> Contractor	<input type="checkbox"/> EIA staff	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> EIA student	<input type="checkbox"/> Visitor	
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:		
<input type="checkbox"/> Injury	<input type="checkbox"/> No injury	<input type="checkbox"/> Near miss
<input type="checkbox"/> Property damage	<input type="checkbox"/> Hazard identified	
The incident was reported to (supervisor):		
Name of Supervisor:		Date: _____

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

Medical treatment	
<p>If MEDICAL EXPENSES or LOST TIME is incurred, a <i>'Workers Compensation Claim form'</i> must be completed and forwarded to WHSW and IM Services 'as soon as possible'.</p>	
Do you intend to seek medical treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you intend to lodge a claim for workers compensation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has any time been lost from work? <i>(More than 1 complete shift)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, have you returned to work?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have/will medical expenses been incurred?	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Uncertain at this time
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](mailto: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)

