LABOUR SPECIALISTS

# INCIDENT REPORT FORM

This form is to be completed following an injury/illness or near miss incident in the workplace. All incidents or potential incidents MUST be reported immediately.

**PART A –** To be completed by a Breeze group representative in affiliation with the injured worker and / or the host employer.

**PERSON COMPLETING FORM**

NAME:______________________________ BRANCH_________________________________

CONTACT NUMBER:_________________________

REPORT DATE: _____/_____/_____ REPORT TIME: _____:_____ AM / PM (PLEASE CIRCLE)

**INJURED PERSON DETAILS**

CANDIDATE NAME: ___________________________ PAYROLL I.D.__________________________

GENDER: _____________________ CONTACT NUMBER:_____________________

DATE OF BIRTH: _____/_____/_____ REGISTRATION DATE: _____/_____/______

OCCUPATION:________________________________ YEARS OF EXPERIENCE IN JOB: ___________

EMAIL: _____________________________________ HOME ADDRESS: _______________________

_____________________________________

HAS THE CANDIDATE LODGED IN A WORKERS COMPENSATION CLAIM BEFORE? YES / NO

EMPLOYMENT STATUS: PERMANENT CASUAL CONTRACTOR FULL-TIME

PART-TIME VISITOR OTHER (PLEASE CIRCLE)

**HOST EMPLOYER DETAILS**

COMPANY NAME: ______________________________________________________________________

CLIENT BOND ID: __________________________________

ADDRESS OF COMPANY: _________________________________________________________________

SUPERVISOR NAME & CONTACT: _________________________________________________________

HAS THE CLIENT PROVIDED A COPY OF THEIR INCIDENT REPORT FORM INCLUDING THE INVESTIGATION REPORT? YES / NO (PLEASE CIRCLE)

*IF NO PLEASE CONTACT THE HOST EMPLOYER FOR THE INCIDENT REPORT.*

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**INCIDENT DETAILS**

WHAT TYPE OF INCIDENT ARE YOU REPORTING? INJURY/ILLNESS NEAR MISS (PLEASE CIRCLE)

INCIDENT DATE: _____/_____/_____ INCIDENT TIME: _____:_____ AM PM

DATE CANDIDATE REPORTED THE INCIDENT: _____/_____/_____ REPORTED TO:_______________

EXACT LOCATION AND ADDRESS OF INCIDENT: ____________________________________________

______________________________________________________________________________

**DESCRIPTION OF INCIDENT / NEAR MISS**

DESCRIBE WHAT HAPPENED AND HOW:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

DATE STOPPED WORK _____/_____/_____ TIME STOPPED WORK _____:_____ AM / PM

TOTAL LOST HOURS ____________ DID THE CANDIDATE RESUME WORK YES / NO

WHAT PART OF THE BODY WAS INJURED?

WHAT TASK WAS BEING UNDERTAKEN AT THE TIME OF THE INCIDENT / ILLNESS (INCLUDING WHAT OBJECT, MACHINE, OR MATERIALS WERE INVOLVED):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**TREATMENT DETAILS**

PLEASE CIRCLE: FIRST AID MEDICAL TREATMENT AMBULANCE CALLED HOSPITALISED

INTEND TO SEEK MEDICAL TREATMENT ALTERNATIVE DUTIES

RETURNED TO NORMAL WORK WORKERS COMPENSATION CLAIM

DIAGNOSIS OF INJURY / ILLNESS: ______________________________________________________

TREATMENT PROVIDED BY: __________________________________________________________

WILL / WAS A WORKERS COMPENSATION CLAIM BE LODGED? ______________________________

**OTHER (PLEASE CIRCLE)**

DID THE NEAR MISS / INCIDENT HAVE AN IMPACT ON THE ENVIROMENT? YES / NO

IF YES PLEASE PROVIDE DETAILS: ____________________________________________

____________________________________________

HAS A SITE INSPECTION BEEN COMPLETED FOR THIS CLIENT? YES / NO

HAS A SITE INSPECTION BEEN COMPLETED FOLLOWING THE INCIDENT? YES / NO

IF NO, WHEN IS THE SITE INSPECTION GOING TO BE COMPLETED? DATE:_____/_____/______

**DETAILS OF WITNESS**

NAME:________________________ POSITION:________________________

CONTACT NUMBER: ________________________

NAME:________________________ POSITION:________________________

CONTACT NUMBER: ________________________

**PART B –** TO BE COMPLETED BY WHS DEPARTMENT

**INCIDENT INVESTIGATION**

CASUAL FACTORS: ____________________________________________

____________________________________________

INVESTIGATION DATE: _____/_____/_____ TIME: _____:_____ AM / PM

CONTRIBUTING FACTORS:

- EMPLOYMENT PLACEMENT
- INADEQUATE PPE
- UNSAFE METHOD
- INADEQUATE EQUIPMENT
- LACK OF KNOWLEDGE / TRAINING
- NO WORK SAFE PRACTICES
- INADEQUATE MAINTENANCE PROGRAMS
- OTHER:

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**RISK ASSESSMENT**

LIKELIHOOD OF RECURRENCE:______________________________________________________________

SEVERITY OF OUTCOME:__________________________________________________________________

LEVEL OF RISK: _______________________________________________________________________

**RECOMMENDED ACTION PLAN**

| FACTOR | CORRECTIVE ACTION | PERSON RESPONSIBLE | TARGET COMPLETION DATE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**WORKERS COMPENSATION CLAIM**

HAS THE CANDIDATE LODGED IN A WORK COVER CLAIM? YES / NO

CLAIM NUMBER: ____________________________ CASE MANAGER:____________________________

**WORK HEALTH AND SAFTEY DEPARTMENT DETAILS**

NAME: _____________________________________ SIGNATURE: ______________________________

DATE: _____/_____/_______