**ACCIDENT / INCIDENT REPORT**

Form 1 Version 2 Feb 2010

 **Date of Incident / /**

**IMPORTANT – PLEASE READ ALL ACCIDENTS / INCIDENTS MUST BE REPORTED**

* Please PRINT or TYPE all details. If there is insufficient space please attach additional information, sketches etc.
* This report must be completed, **signed** and faxed to 03 6452 4980 (HR) within **24 hours** of an accident / incident or near miss occurring.
* Forward the **original** to ABC Offices, Human Resources (HR) PO Box 37, Smithton, TAS 7330.
* **STAFF ONLY** – If lodging a **Workers Compensation Claim** you must contact your Human Resources Office, nominate a treating doctor and obtain a WorkCover Medical Certificate.
* **VISITORS ONLY** – If lodging an insurance claim, information and forms are available from HR Support Officers.
* This report is **CONFIDENTIAL** and information provided is protected by the Privacy and Personal Information Protection Act 1998 (NSW), and the Health Records and Information Privacy Act 2002 (NSW) however you should be aware that Human Resources will distribute a copy of the report to relevant parties for the purpose of investigation and insurance. Please contact Human Resources

office should you require further information.

**Details of the injured person are to be completed by person/first aid officer/witness**

Location/site: First Name: Last Name:

Residential Address:

Is Person: Staff  Contractor  Visitor  Gender: Male  Female 

Staff/Contractor No: Date of Birth: Position:

Location/Section: Telephone: Home Work

Supervisor: Employment Status Full Time  Part Time  Casual 

Date Occurred: Time Occurred: am/pm Location:

Nature of Accident/Incident or Injury (e.g. laceration, sprain, near miss, vehicle accident):

Area of Damage/Part of Body Injured (e.g. none, right leg, crumpled car bumper):

State exactly how accident/incident occurred:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Returned to Work |  | First Aid Only |  | Attended Doctor |  | Attended Hospital |
| Yes | No |  | Yes | No |  | Yes | No |  | Yes | No |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| If No – Date Stopped |  | First Aid Only |  | Attended Doctor |  | Attended Hospital |
|  |  |  |  |  |  |  |

Details of Treatment (e.g. ice applied):

(Should the illness/injury worsen please forward an updated Accident/Incident Report Form)

Witness/s Name

 Address

 Phone No

Details of Hazards:

|  |  |  |
| --- | --- | --- |
| Have you submitted a |  | Does this incident involve a |
| BEIMS Request |  | Hazard Report |  | Radiation Hazard |  | Biological Hazard |  | Chemical Hazard |
| Yes | No |  | Yes | No |  | Yes | No |  | Yes | No |  | Yes | No |

 If so attach details from relevant section of applicable Safety Manual

 Person Completing Report (print name) Signature Date