**🞎 BRISBANE 🞎 TOWNSVILLE**

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| **EMPLOYEE DETAILS** | | | | | |
| Name: |  | | | Date of Birth: |  |
| Address: |  | | | | |
| Home Phone: |  | Mobile: |  | Occupation: |  |
| Date Employed: |  | | | Sex: | 🞎 Female 🞎 Male |
| Employment: | 🞎 Full time employee 🞎 Part time employee 🞎 Casual Employee 🞎 Volunteer | | | | |

🞎 First aid injury 🞎 Medical Treatment Injury 🞎 Lost Time Injury 🞎 Near Miss

🞎 Property Damage 🞎 Government Notifiable Event 🞎 Notification only

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| **INCIDENT DETAILS** | | | |
| Date of Incident: |  | Time of Incident: |  |
| Date reported to Spinal Injuries Association: |  | Who was it first reported to: |  |
| Client Name  (if applicable): |  | Client Address  (if applicable): |  |

🞎 On duty 🞎 On duty and in motor vehicle accident 🞎 On a work break

🞎 Travelling to or from work 🞎 Other. Please specify:

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| What was the actual job being performed when the incident occurred? |  | |
| Describe what actually happened? |  | |
| Was this activity part of your normal routine? If not, please explain the circumstances which required this activity to be undertaken. |  | |
| Did anyone witness the incident? (Please provide name, address and telephone number). | Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **INJURY OUTCOME** | | | |
| Injury/Illness Description: |  | **FRONT VIEW**  Right Left | **BACK VIEW**  Left Right |
| Did you require any medical attention for your injury? | 🞎 Nil  🞎 First aid only  🞎 Doctor consulted  🞎 Hospital  Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Workers Compensation Form required? | 🞎 Yes 🞎 No |
| Did you continue to work after the incident? | 🞎 Yes 🞎 No |

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| **EQUIPMENT BEING USED (if involved in incident)** | | | |
| Type: |  | Model/Make: |  |
| Was the equipment in good working order? | 🞎 Yes 🞎 No Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| **PERSONAL PROTECTIVE EQUIPMENT (PPE)** | |
| Should PPE (eg. gloves) have been worn for the task being undertaken? | 🞎 Yes 🞎 No |
| Was it being worn/used? | 🞎 Yes 🞎 No |
| Was it available? | 🞎 Yes 🞎 No |
| Type of PPE required? | Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **WORKER’S DECLARATION - I declare the above information is correct and not misleading** | | |
| **WORKER’S Name** | **Signature** | **Date** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_** |

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| **INCIDENT INVESTIGATION** to be completed by the person investigating | | | | |
| What were the main contributing factors? |  | | | |
| **RISK**  **ASSESSMENT** | | **Consequences**  1. Insignificant 2. Minor 3. Moderate 4. Major 5. Catastrophic | | **Risk Score**  (Likelihood +  Consequences  scores) |
| **Likelihood**  1. Rare 2. Unlikely 3. Possible 4. Likely 5. Almost Certain | |
| **Type of Incident**  🞎 Slips/trips/falls  🞎 Repetitive action  🞎 Hitting an object  🞎 Manual Handling  (Body Stressing)  🞎 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 🞎 Abrasion/Bruise  🞎 Cuts/sharps  🞎 Heat/temperature  🞎 Mental stress  🞎 Electricity  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Cause of Incident**  🞎 Equipment/plant  🞎 Vehicle  🞎 Client/human factors  🞎 Tools/Static equipment  (e.g. computer)  🞎 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 Environment  🞎 Hazardous substances  🞎 Live animals  🞎 Bodily Fluids  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **CORRECTIVE/PREVENTATIVE ACTIONS** | | | |
| **Proposed** | **Responsibility** | **Proposed Date** | **Actual**  **Date** |
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| **COMMENTS** on implementing the corrective/preventative actions recommended above |
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| **VALIDATION** The undersigned have investigated this incident and do state this information is the best available information according to the known facts. | | |
| **Investigator (Manager - Workplace Health & Safety)** | **Signature** | **Date** |
|  |  |  |
| **Supervisor** | **Signature** | **Date** |
|  |  |  |
| **Manager** | **Signature** | **Date** |
|  |  |  |