**AFEI Member Template: Incident Report Form**

**THIS DOCUMENT IS ONLY A GUIDE**

AFEI recommends members consider their specific requirements when adopting a template document or policy to ensure the document meets the particular needs of your organisation.

For assistance, please call the AFEI Hotline on 02 9264 2000.

**How to use this document:**

1: Check with the AFEI Hotline as to its suitability for your needs.

2: Edit to meet your requirements by:

* **Add** relevant information in the [yellow highlighted] sections.
* **Delete** comments in the *[blue highlighted]* areas.

***[Place on Organisation Letterhead]***

Incident Report Form

**Type of Incident**:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Near Miss |  | First Aid Treatment |
|  | Medical Treatment (no time lost) |  | Medical treatment (work time lost) |
|  | Workers Compensation Claim |  | Notifiable Incident (to state Regulatory Authority) |
|  | Property Damage |  |  |
|  | Other (e.g. Public Liability – Specify): | | |

**The person involved**: (the person injured or directly affected).

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Residential Address: |  |
| Age: |  | Role: |  |
| Position: |  | Manager’s Name: |  |

**The Incident:** (What happened and who saw it).

|  |  |  |  |
| --- | --- | --- | --- |
| Date: |  | Time: | \_\_\_\_\_\_\_\_\_\_AM \_\_\_\_\_\_\_\_\_PM |
| Location: |  | | |
| What Happened? |  | | |
| What was Injured? |  | | |
| What was damaged? |  | | |

|  |  |
| --- | --- |
| Witnesses? | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**After the Incident**: (What was done immediately afterwards)

|  |  |
| --- | --- |
| What happened after the incident (E.g. Ambulance / Police called, first aid given)? |  |
| Who was the incident reported to? (E.g. Manager, SafeWork / WorkCover/Client) |  |
| Does anything need to be done immediately to protect others? |  |

**Declaration by person completing form:**

I declare this to be a true account of the incident to the best of my understanding as a witness, or, as the incident was described to me.

|  |
| --- |
| Name of person who described the incident to you (*if you did not witness the incident yourself*): |

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Role:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Manager Review:**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Role:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Comments:** |  |