



ACCIDENT, INCIDENT AND HAZARD NOTIFICATION FORM

Accident, Incident and Hazard Notification Form			
Name of Employee/Volunteer:	Effective Date:		
Address:	Country of Birth: (WorkCover Requirement)		
Phone Number:	Location:		
Date of Incident:/...../.....	Department:		
Location of accident/incident/hazard:	Time of Incident:am/pm		

Nature of Notification		Action Taken:		Lost Time:
Accident	<input type="checkbox"/>	<i>First Aid</i>	<input type="checkbox"/>	No <input type="checkbox"/>
Near Miss/Incident	<input type="checkbox"/>	<i>Medical Treatment</i>	<input type="checkbox"/>	Yes <input type="checkbox"/>
Hazard	<input type="checkbox"/>	<i>Housekeeping/general cleaning</i>	<input type="checkbox"/>	If yes, specific details:
Other:	<input type="checkbox"/>	Other:	<input type="checkbox"/>	
Description of Accident/Incident/hazard		Please provide as much detail as possible to describe the accident/incident or hazard		

Injury

Part of Body Injured:	
Nature of Injury:	
Details of Injury/Treatment	



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Investigation			
Type of Accident/Incident/Hazard		Agent of Injury:	
Slip/trip/fail	<input type="checkbox"/>	Plant/machinery	<input type="checkbox"/>
Cut/Sharps	<input type="checkbox"/>	Environment	<input type="checkbox"/>
Striking an object	<input type="checkbox"/>	Vehicle	<input type="checkbox"/>
Manual Handling	<input type="checkbox"/>	Static equipment (e.g. computer work station)	<input type="checkbox"/>
Extreme Temperature	<input type="checkbox"/>	Hazardous Substance	<input type="checkbox"/>
Repetitive muscular/skeletal injury	<input type="checkbox"/>	Hand tool	<input type="checkbox"/>
Abrasion/bruise	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Other:	<input type="checkbox"/>		
Details of Witnesses:			
Signature of person completing form: _____		Date: _____	

SUPERVISOR/MANAGER TO INVESTIGATE AND COMPLETE THIS SECTION			
Prevention			
What action can be taken to prevent recurrence?			
Equipment Machinery Modification or Maintenance	<input type="checkbox"/>	Improve personal protection	<input type="checkbox"/>
Improved design/construction	<input type="checkbox"/>	Enhanced training and instruction	<input type="checkbox"/>
Change to work procedures	<input type="checkbox"/>	Use of safer materials	<input type="checkbox"/>
Improved housekeeping	<input type="checkbox"/>	Re-education of staff	<input type="checkbox"/>
Improved work organisation	<input type="checkbox"/>	Other:	
Specify measure(s) already taken:			
Any further comments			
Supervisor Details			
Name: _____		Signature: _____	
		Date: _____	



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OH&S Committee Review		
Investigation/Review Completed:	YES <input type="checkbox"/>	NO <input type="checkbox"/>
If No – Further Action/Recommendations required:		
OH&S Chairperson details		
Name: _____	Signature: _____	Date: _____