**Type of Incident**:

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Residential Address:  |  |
| Age: |  | Role (Or status, e.g. client): |  |
| Manager’s name (If relevant): |  | Other relevant details: |  |

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

|  |  |  |  |
| --- | --- | --- | --- |
| Date: |  | Time:  | \_\_\_\_\_\_\_\_\_\_AM \_\_\_\_\_\_\_\_\_PM |
| Location: |  |
| What Happened? |  |
| **Who** was injured?or**What** was damaged?or What could have been the consequence (e.g. near miss)? |  |
| Witnesses?Include Name and Phone Number for all witnesses. |  |

**After the Incident**:

|  |  |
| --- | --- |
| What happened immediately after the incident (e.g. Ambulance / Police called, first aid given)? |  |
| Who was the incident reported to (e.g. Manager, SafeWork NSW, Client)? |  |
| What immediate corrective actions were undertaken? |  |

**Declaration by person completing form:**

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

|  |  |
| --- | --- |
| Person who described the incident to you (if you did not witness the incident yourself):  |  |

Your Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of report: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Manager Review**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



|  |  |
| --- | --- |
| Comments: |  |
| Is an investigation required? |  |