



U3A Rockhampton and District Inc.
ABN 83 907 668 103

Incident Report Form

PART A – Details of the incident

Details of the person completing the report	Name:
	Contact phone number:
	Email address:
	Position: <input type="checkbox"/> Committee Member <input type="checkbox"/> Coordinator <input type="checkbox"/> First Aid Person <input type="checkbox"/> Other _____
Time and date of incident	_____ : _____ am/pm on ____/____/____
Type of incident	<input type="checkbox"/> Incident <input type="checkbox"/> Accident <input type="checkbox"/> Near Miss
Location of incident	
Person at venue notified	
Activity being undertaken	<input type="checkbox"/> General Meeting <input type="checkbox"/> Committee Meeting <input type="checkbox"/> Activity Group _____ <input type="checkbox"/> Other _____
Brief description of incident or near miss (if insufficient space, please attach a separate incident report)	
Names and contact details for witnesses to the incident	
Was anyone injured	<input type="checkbox"/> No (complete Part B) <input type="checkbox"/> Yes (complete Part C for each injured person) How many:

Name of person completing form: _____ Signature: _____

Date: ____/____/____

N.B. This form is to be treated as "CONFIDENTIAL". Please retain the original and forward a copy to the Safety Management Team.

PART B – Investigation

Time and date of incident: _____: _____ am/pm on ____/____/____

Investigation Methods	<input type="checkbox"/> interviews <input type="checkbox"/> written statements <input type="checkbox"/> examination of accident site <input type="checkbox"/> CCTV review <input type="checkbox"/> Photographs <input type="checkbox"/> Other: _____
Brief Summary of findings (refer to attachments if necessary)	
Causal factors identified	<input type="checkbox"/> People: _____ <input type="checkbox"/> Equipment/plant: _____ <input type="checkbox"/> Environment: _____ <input type="checkbox"/> Processes/procedures: _____ <input type="checkbox"/> Organisational factors: _____
Recommendations (refer to hierarchy of controls)	<input type="checkbox"/> Elimination: _____ <input type="checkbox"/> Substitution: _____ <input type="checkbox"/> Isolation: _____ <input type="checkbox"/> Engineering: _____ <input type="checkbox"/> Administrative: _____ <input type="checkbox"/> Personal protective equipment: _____
Will recommendations eliminate all hazards?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Photographs of involved items and reenactment to be included with this report	<input type="checkbox"/> Yes (Of what) _____ <input type="checkbox"/> No (Why) _____

Name of person completing form: _____ Signature: _____

Date: ____/____/____

Date copy submitted to Health and Safety Officer: ____/____/____

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PART C – Details of injury

Time and date of incident: _____ am/pm on ____/____/____

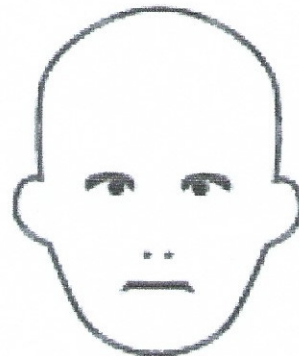
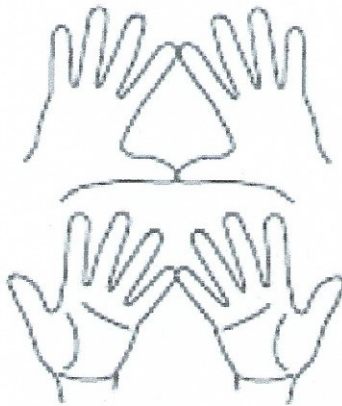
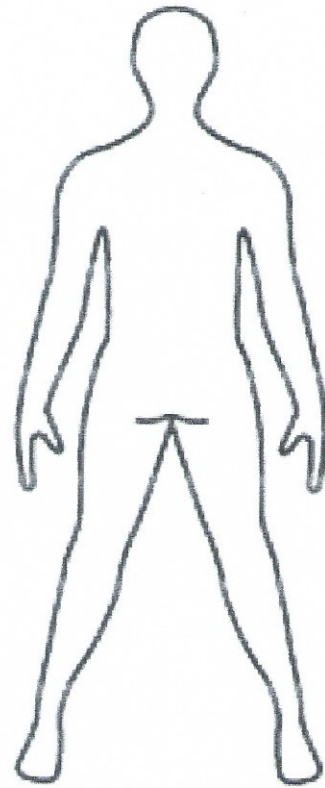
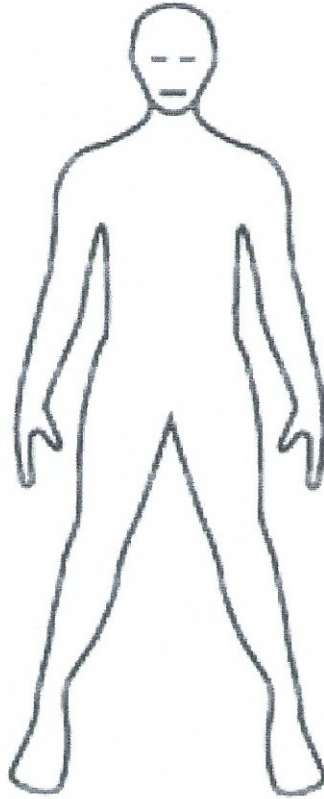
N.B. If more than one person has been injured in this incident, please attach an additional part B for each injured person

Details of injured person	Name: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth: ____/____/____
Contact Details	Work phone _____ Home phone _____ Mobile _____ Email: _____ Address: _____
Relationship with U3A	<input type="checkbox"/> Member <input type="checkbox"/> Visitor <input type="checkbox"/> Guest <input type="checkbox"/> Other _____
Insurance Claim	Will an Insurance claim be lodged? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

Mechanism of Injury (indicate all relevant)	<input type="checkbox"/> Slip/trip/fall <input type="checkbox"/> Manual handling <input type="checkbox"/> Body stressing <input type="checkbox"/> Being hit by falling object <input type="checkbox"/> Hitting an object with part of the body <input type="checkbox"/> Being hit by moving objects <input type="checkbox"/> Exposure to heat /radiation /electricity <input type="checkbox"/> Exposure to biological agent (including body fluid) <input type="checkbox"/> Exposure to chemical agent <input type="checkbox"/> Exposure to asbestos <input type="checkbox"/> Exposure to work stress <input type="checkbox"/> Violence <input type="checkbox"/> Other inappropriate behaviour <input type="checkbox"/> Other: _____
Nature of Injury (indicate all relevant)	<input type="checkbox"/> Sprain/Strain <input type="checkbox"/> Fracture <input type="checkbox"/> Cuts/Scratch/Abrasion <input type="checkbox"/> Bruising <input type="checkbox"/> Burn <input type="checkbox"/> Bite/Sting <input type="checkbox"/> Electrical shock <input type="checkbox"/> Concussion <input type="checkbox"/> Psychological <input type="checkbox"/> Other _____

Bodily Location/s

Put a cross on the parts of the body that are injured



Treatment required (highest level only)

- No treatment First Aid Doctor Hospital outpatient Hospital admission
 Other _____

Name of person completing form: _____ Signature: _____

Date: ____/____/____

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PART D – Actions
(To be completed by the Safety Management Team)

Time and date of incident: _____ : _____ am/pm on ____/____/____

* N.B. Actions are to be reviewed and approved by the committee of U3A Rockhampton and District Inc.

Confirmation of actions	<p>Are all recommendations accepted? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Note exceptions:</p>
Additional actions to be taken	CONFIDENTIAL
Actions completed	Are all actions completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Update Risk Assessment Form	Has Risk Assessment Form for the venue/activity been updated as soon as possible after the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No
Transfer to Risk Register	All remaining hazards transferred to the risk register for monitoring/review? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Outstanding actions	All outstanding actions noted against hazards in the risk register: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Communication	<p><input type="checkbox"/> Person reporting incident notified of outcomes on ____/____/____</p> <p><input type="checkbox"/> Relevant committee notified of incident and outcomes on ____/____/____</p> <p><input type="checkbox"/> Copy of this complete Incident Report Form sent to Assistant Secretary for filing.</p>

Name: _____ **Signature:** _____ **Date:** ____/____/____

Date reviewed by Committee: ____/____/____ **Date sent for filing:** ____/____/____