

INCIDENT REPORT FORM – GENERAL

Use this form to report an accident, incident or near-hit. Give the form to your Manager once completed and submitted to PKRacer.

Personal details (name of person involved)

First name(s)*:	Surname*:	DOB: / /
Address:		
Telephone number*:	Email address:	

Incident details (to be completed with the person or guardian involved)

Date of incident*: / /	Time of incident*:
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Location of incident (eg Bumperboats, Trampolines, Laser Tag):

Description of incident (please include as much detail as you can):

Could anything have prevented the accident from occurring? Circle: YES NO

If so, please provide comment below:

Primary Injury or Disease:

(Tick Primary injury. If more than one, tick Multiple Injuries)

- | | |
|---|---|
| <input type="checkbox"/> Strain/Sprain - Pain Gradual | <input type="checkbox"/> Burns |
| <input type="checkbox"/> Strain/Sprain - Pain Sudden | <input type="checkbox"/> Dermatitis |
| <input type="checkbox"/> Cut / Open Wound | <input type="checkbox"/> Chemical Exposure |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> Crushing | <input type="checkbox"/> Electrocutation |
| <input type="checkbox"/> Dislocation | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Fracture | <input type="checkbox"/> Impact Injury |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Foreign Body |
| <input type="checkbox"/> Acute Hearing Loss | <input type="checkbox"/> Breathing Difficulties |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Multiple Injuries |
| <input type="checkbox"/> Infectious /Parasitic Disease: _____ | |

I was injured by: (Mechanism of Injury -Tick one)

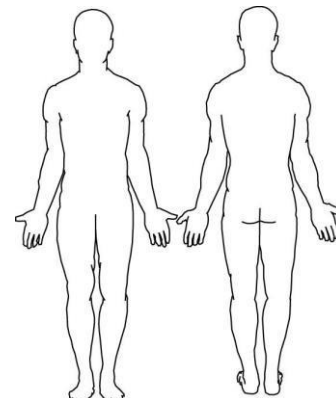
- | | |
|--|---|
| <input type="checkbox"/> Slip /Trip / Fall | <input type="checkbox"/> Sound / Pressure |
| <input type="checkbox"/> Body Stressing | <input type="checkbox"/> Biological Factors |
| <input type="checkbox"/> Heat / Radiation / Energy | <input type="checkbox"/> Mental Stress |
| <input type="checkbox"/> Hitting object with body | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Chemicals / other Substance | <input type="checkbox"/> Moving object |

CAUSE OF HARM

Which of these injured or potentially injured me? (Tick one)

- | | |
|---|---|
| <input type="checkbox"/> Machinery / Fixed Plant | <input type="checkbox"/> Chemical |
| <input type="checkbox"/> Mobile Plant / Machinery | <input type="checkbox"/> Material |
| <input type="checkbox"/> Powered Equipment / Tool / Appliance | <input type="checkbox"/> Substance |
| <input type="checkbox"/> Biological | <input type="checkbox"/> Animal / Human |
| <input type="checkbox"/> Non-powered Tool / Appliance / Equipment | |

Circle where the injury is located on your body:



Details of other persons involved

Did the incident involve any other person or witness?	<input type="radio"/> Yes	<input type="radio"/> No
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	If yes, was the other person injured?	
(If yes, provide their names and contact details)		

Other details (Management to complete this section)		
Did any damage to property occur?	<input type="radio"/> Yes	<input type="radio"/> No
<i>(If yes, provide details of the damage)</i>		
Were the Police involved?	<input type="radio"/> Yes	<input type="radio"/> No
<i>(If yes, provide details of the officers attending)</i>		
Was the regulator (e.g. WorkSafe) informed?*	<input type="radio"/> Yes	<input type="radio"/> No
Is this an accident compensation related incident?	<input type="radio"/> Yes	<input type="radio"/> No

*WorkSafe *must* be informed of a notifiable illness, injury or a notifiable event occurring in the workplace.

Your Name: _____
 Person Reporting Event

Signature: _____
 Person Reporting Event

Date: _____

Manager's Name: _____

Manager's Signature: _____

Date: _____