PROKARTS

INCIDENT REPORT FORM

Use this form to report an accident, incident or near-hit. Give the form to your Manager or the person in charge of health and safety in your workplace.

Personal details *(name of person involved)*

First name(s):	**Surname:**	**DOB: / /**
Address:		
Telephone number:	**Email address:**	
Your name(s):	**Position:**	
Managers Name:		

Incident details *(completed by person involved)*

Date of incident: / /	**Time of incident:**
Location of incident:	
Description of incident: *(in your own words, what happened?)*	

Primary Injury or Disease:
(Tick Primary injury. If more than one, tick Multiple Injuries)

- ☐ Strain/Sprain - Pain Gradual
- ☐ Strain/Sprain - Pain Sudden
- ☐ Cut / Open Wound
- ☐ Bruising
- ☐ Crushing
- ☐ Dislocation
- ☐ Fracture
- ☐ Fatigue
- ☐ Acute Hearing Loss
- ☐ Other:____________
- ☐ Burns
- ☐ Dermatitis
- ☐ Chemical Exposure
- ☐ Poisoning
- ☐ Electrocution
- ☐ Concussion
- ☐ Impact Injury
- ☐ Foreign Body
- ☐ Breathing Difficulties
- ☐ Multiple Injuries
- ☐ Infectious /Parasitic Disease: _________________

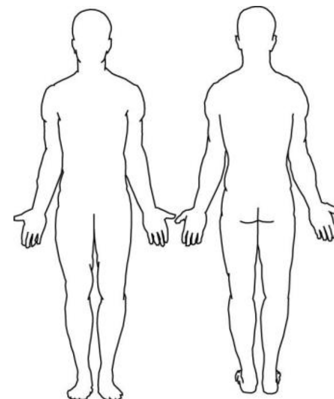
I was injured by: (Mechanism of Injury -Tick one)

- ☐ Slip /Trip / Fall
- ☐ Body Stressing
- ☐ Heat / Radiation / Energy
- ☐ Hitting object with body
- ☐ Chemicals / other Substance
- ☐ Sound / Pressure
- ☐ Biological Factors
- ☐ Mental Stress
- ☐ Fatigue
- ☐ Moving object

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

- ☐ Machinery / Fixed Plant
- ☐ Mobile Plant / Machinery
- ☐ Powered Equipment / Tool / Appliance
- ☐ Biological
- ☐ Non-powered Tool / Appliance / Equipment
- ☐Chemical
- ☐ Material
- ☐ Substance
- ☐ Animal / Human

Circle where the injury is located on your body:



Details of other persons involved

Did the incident involve any other person or witness?	○ Yes	○ No
	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?	○ Yes	○ No
(If yes, provide details of the damage)		
Were the Police involved?	○ Yes	○ No
(If yes, provide details of the officers attending)		
Was the regulator (e.g. WorkSafe) informed?*	○ Yes	○ No
Is this an accident compensation related incident?	○ Yes	○ No

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

Your Name: ____
(If different to above / Person Reporting Event)

Signature: ____ **Date:** _______________
(Injured party / Person Reporting Event)

ONCE COMPLETED PLEASE **PRIVATE MESSAGE** THIS FORM TO NICK VIA "WORK CHAT" & THEN PUT THIS FORM IN THE ACCEDIENT REPORT FOLDER