



# HAZARD, INCIDENT & INJURY REPORT FORM



Please draw a diagram of how the incident / Hazard occurred and its location (if appropriate).

**Please describe in your own words how this incident/hazard may be avoided in the future:**


**Were any services called to the incident?**

No   
  Yes                     
  Police   
  Ambulance   
  Fire   
  Other (please specify):

**List any witnesses:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Mobile: \_\_\_\_\_ Phone: \_\_\_\_\_

**PERSONAL DETAILS OF INJURED PERSON (Section 6.0 of Hazard, Incident and Injury Procedure)**

Full Name:		Position:	
Department:		Section:	
Phone:			
Address:			

Status:   
 Full Time Employee of Indigo Council   
 Part Time Employee of Indigo Council

Casual Employee of Indigo Council   
 Contractor/Subcontractor of Indigo Council

Volunteer of Indigo Council                     
 Member Of Public

Other (please specify: e.g. Member of Public) \_\_\_\_\_

If Employee, Hours Normally worked for Indigo Council (from/to): \_\_\_\_\_ Days Usually Worked: S S M T W T F

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09/311	COR.F.010	3	A CUDARS	23.8.2010				12 MONTHS



**NATURE OF SUSPECTED INJURY:** Try and work out what type of injury has occurred. To be filled in by a designated Indigo Shire Council First Aider if possible

Description of injury/illness: (e.g. 2cm cut to left hand palm)

Describe first aid treatment given: (e.g. Placed bandage over cut)

**Nature of injury: Injury type, what type of injury has occurred?**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Allergy or sensitivity        | <input type="checkbox"/> Exposure effects heat/cold | <input type="checkbox"/> Multiple injuries             |
| <input type="checkbox"/> Amputation                    | <input type="checkbox"/> Fainting                   | <input type="checkbox"/> Nausea/vomiting               |
| <input type="checkbox"/> Asphyxiation                  | <input type="checkbox"/> Foreign body               | <input type="checkbox"/> Poisoning/toxic effects       |
| <input type="checkbox"/> Bruising                      | <input type="checkbox"/> Fracture/dislocation       | <input type="checkbox"/> Puncture                      |
| <input type="checkbox"/> Burn/scalds                   | <input type="checkbox"/> Hearing loss               | <input type="checkbox"/> Respiratory                   |
| <input type="checkbox"/> Contusion/crush               | <input type="checkbox"/> Hernia                     | <input type="checkbox"/> Superficial wound or abrasion |
| <input type="checkbox"/> Damage to artificial aids     | <input type="checkbox"/> Internal injuries          | <input type="checkbox"/> Sprain/strain                 |
| <input type="checkbox"/> Electric shock or effects     | <input type="checkbox"/> Laceration/deep cut        | <input type="checkbox"/> Vision impairment             |
| <input type="checkbox"/> Other (please specify):-..... |   |  |

**Part of body affected:**

- |  |                                    |  |  |
|--|------------------------------------|--|--|
| <input type="checkbox"/> Left                    | <input type="checkbox"/> Right     | <input type="checkbox"/> Front         | <input type="checkbox"/> Back          |
| <input type="checkbox"/> Head                    | <input type="checkbox"/> Neck      | <input type="checkbox"/> Forearm       | <input type="checkbox"/> Chest         |
| <input type="checkbox"/> Face                    | <input type="checkbox"/> Shoulder  | <input type="checkbox"/> Wrist         | <input type="checkbox"/> Back          |
| <input type="checkbox"/> Ear                     | <input type="checkbox"/> Upper arm | <input type="checkbox"/> Hand          | <input type="checkbox"/> Stomach/trunk |
| <input type="checkbox"/> Eye                     | <input type="checkbox"/> Elbow     | <input type="checkbox"/> Fingers/thumb | <input type="checkbox"/> Groin/hip     |
| <input type="checkbox"/> Other (please specify): | <input type="checkbox"/> Buttock   | <input type="checkbox"/> Thigh         | <input type="checkbox"/> Knee          |
|  | <input type="checkbox"/> Shin/calf | <input type="checkbox"/> Ankle         | <input type="checkbox"/> Foot/toe      |
|  | <input type="checkbox"/> Internal  |  |  |

**Agency of injury (what caused the injury?)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Animal/Insect                     | <input type="checkbox"/> Mobile plant/Equipment | <input type="checkbox"/> Situation – violence, assault |
| <input type="checkbox"/> Biological agent (e.g. pathogens) | <input type="checkbox"/> Needle/Sharp           | <input type="checkbox"/> Surface (slippery/rough)      |
| <input type="checkbox"/> Chemical                          | <input type="checkbox"/> Noise                  | <input type="checkbox"/> Thermal (heat/cold)           |
| <input type="checkbox"/> Electrical                        | <input type="checkbox"/> Non-power tool         | <input type="checkbox"/> Vehicle/Transport             |
| <input type="checkbox"/> Explosion/implosion               | <input type="checkbox"/> Objects                | <input type="checkbox"/> Workstation design            |
| <input type="checkbox"/> Lifting/Carrying                  | <input type="checkbox"/> Power tools            |  |
| <input type="checkbox"/> Machinery/Fixed plant             | <input type="checkbox"/> Repetitive work        |  |
| <input type="checkbox"/> Other (please specify):           |   |  |

	Name	Signature	Date
<b>INJURED PERSON</b>			
<b>FIRST AID PROVIDER</b>			

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<b>To be filled in by the Manager/Supervisor/Foreman responsible for area where the incident occurred</b>			
<b>Does the Incident/Injury Require reporting to WorkSafe (Section 7.0)</b>		<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>Level of Risk (Section 5.0)</b>		<input type="checkbox"/> Extreme/High	<input type="checkbox"/> Medium <input type="checkbox"/> Low
<b>Is an Investigation / Risk Assessment Required (Section 8.0)</b>		<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>Supervisor / Foreman / Managers Details</b>			
Name:			
Position:		Department:	
Signature:		Date:	
<b>If work related please state the name of the Health and Safety Representative (HSR) for the area that was consulted.</b>		HSR's Name:	
<b>Actions To Prevent a Reoccurrence: (Section 9.0)</b>			<b>By Who</b>
			<b>Due Date</b>
<b>Entered Into Conquest/Merit</b>		<input type="checkbox"/> YES	<input type="checkbox"/> NO
		Reference No _____	

**REPORTING PROCESS ONCE FORM IS COMPLETED**

- **Please note that each department and/or person is in its correct order**

Reporting System	Name	Signature	Date
<b>1. Supervisor/Coordinator/Direct Manager</b>			
<b>2. TRIM</b> Give original/Scan/Email /Fax to Records Department to TRIM, , <b>Assignee to relevant Manager where incident occurred</b> <b>Original of TRIMED report to OHS Coordinator</b>			
<b>3. Copy of TRIMED document to the following when</b> <b>OD Department - employee injury and/or</b> <b>Manager Governance and Risk - for injury to public or/and</b> <b>Fleet Manager - for incidents involving ISC Fleet</b>			

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