

INCIDENT REPORT FORM

Please **PRINT** all details when completing this form. If there is insufficient space on this form, please attach additional information, sketches, photographs etc.

This report must be completed, signed and an electronic or hard copy provided to Axxis Project Training's CEO within 24 hours of an accident/incident or near miss occurring. Scanned copies should be emailed to ceo@axxis.training. The original should be handed to, or sent to the CEO at 1/24 Huntington Street, Clontarf, Qld 4019.

This report is **CONFIDENTIAL** and information provided is protected by the Privacy Act and relevant Health Record Information Privacy legislation. That being said, this report may be distributed to relevant parties for the purpose of investigation and/or insurance. Please contact our administrative office if you require further information.

DETAILS OF PERSON INVOLVED:

Student Trainer Other Staff Visitor/Bystander

Full Name:

Gender:

Female Male

Date of Birth:

/ /

Full Residential Address:

Contact Phone No:

Signature:

DETAILS OF INCIDENT:

Personal Injury Property Damage Motor Vehicle Near Miss Other

Brief Description of Incident/Accident *(what happened)*

Date and time of incident:

Date and time reported:

/ / at : AM / PM / / at : AM / PM

Location of Incident:

Did the incident involve plant, equipment or an object? *(Specify)*

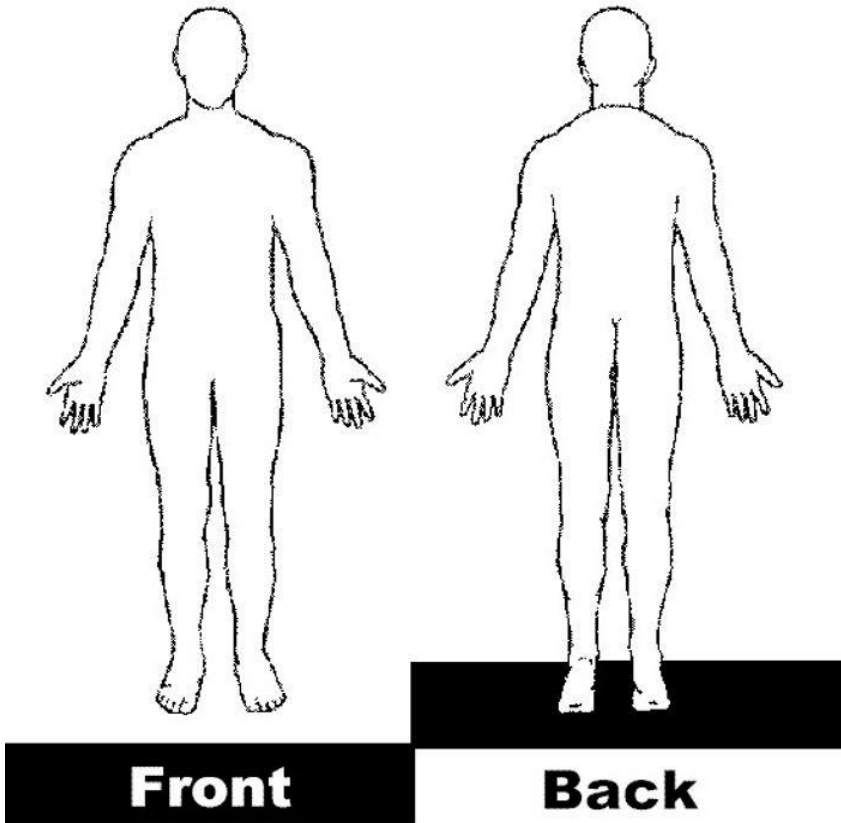
Did the incident involve chemicals or substances? *(Specify)*

DETAILS OF PERSONAL INJURY: (If no injury or illness skip this section)

Injury Type:
 Laceration/Cut Bruising Sprain/Strain Trip/Fall/Slip Object in eye
 Other (Specify):

Was First Aid provided? **If yes, who provided First Aid?**
 Yes No Name:

Indicate on diagram where injury occurred:



Was further first aid or medical treatment required? Yes No
If yes, provide details including type and extent of treatment, timeframe, location, details of the first aider/doctor/paramedic etc.

DETAILS OF WITNESSES: (If more than 3, please attach details)

Student Trainer Other Staff Visitor/Bystander

Full Name:

Gender: Female Male **Contact Phone No:**

Full Residential Address:

Email:

Witness 2:

Student Trainer Other Staff Visitor/Bystander

Full Name:

Gender: Female Male **Contact Phone No:**

Full Residential Address:

Email:

Witness 3:

Student Trainer Other Staff Visitor/Bystander

Full Name:

Gender: Female Male **Contact Phone No:**

Full Residential Address:

Email:

INCIDENT RESPONSE: (To be completed by the trainer/supervisor)

Treatment given to injured person:

More than one selection may apply (tick as many as appropriate)

Nil First Aid General Practitioner Hospital (ED) Hospital (In-patient)

Is Debriefing/Counselling required? Yes No

If yes, contact the WHS Manager with details of the person/people that require debriefing or counselling.

Is this a notifiable incident? Yes No

If yes, contact the CEO with details of the incident. If you are uncertain about whether an incident is notifiable or not call WorkSafe on 1300 362 128 to seek advice.

Were emergency services notified? Yes No

If yes, nominate the services notified below:

Ambulance Police Fire Local Government Services

Risk Management:

Use the APT Risk Assessment tools to determine the appropriate control/s and indicate here:

Elimination Substitution Isolation Engineering Administrative PPE

Consult the WHS Manager to discuss immediate corrective actions taken and those planned prior to implementation.

Name of trainer/supervisor completing this report:

Full Name:

Contact Phone No:

Signature:

