

WHS INCIDENT REPORT FORM



This form is to document workplace injuries, illnesses, near misses, and other safety-related incidents.

The information provided on this form will be handled in accordance with the *Privacy Act 1988 (Cth)* and the Australian Privacy Principles (APPs), and will only be used, stored and disclosed for purposes related to incident management, workplace health and safety, injury management, rehabilitation, and other lawful obligations.

This form must be completed within 30 days of the incident/injury occurring.

Please send to **pc.help@aflsportsready.com.au**

Person Involved

First Name and Surname:	
Home Address:	
Phone:	
Email:	
Date of birth:	
Gender:	
Employment Type:	☐ Staff ☐ Trainee/Apprentice ☐ Contractor ☐ Visitor
Host Employer:	
Worksite Address:	
Supervisor:	
Phone:	
Email:	

Incident Details

Date of incident:	
Location of incident:	
Approx. Time:	Time: ☐ AM ☐ PM
Report Type:	☐ Injury ☐ Near Miss ☐ Illness ☐ Hazard ☐ Property Damage
Incident type:	☐ Slip, Trip, Fall ☐ Manual Handling ☐ Struck by Object ☐ Electrical ☐ Motor Vehicle ☐ Other Transport ☐ Chemical ☐ Other
Notifiable incident*:	☐ Yes ☐ No
Description of what happened:	
Any witnesses?	☐ Yes ☐ No
Witness Name:	
Witness Phone:	

Injury Details

Nature of injury:

(e.g. Fracture, dislocation, burns)

Body location:

(e.g. Head, foot, lower back)

Cause of injury:

(e.g. Contact with electricity, vehicle accident)

Agency of injury:

(e.g. Machinery, chemicals)

Details:

Treatment sought:

☐ Yes ☐ No

Treatment type:

☐ First Aid ☐ GP ☐ Hospital ☐ Other:

Treated by:

(Name of practitioner, Address)

Phone:

Treatment date:

Returned to work?

☐ Yes ☐ No

Date returned to work:

Duties performed:

☐ Pre-injury duties ☐ Suitable Duties ☐ Totally unfit for duties

Any special requirements:

Declaration

I certify that the information I have provided is correct. I understand that if any information I have given is untrue, that my claim may be denied and that I may be prosecuted. I consent to AFL SportsReady collecting and using my personal information, and/or disclosing these details to medical practitioners, investigators and other experts, for the purpose of assessing and managing my claim.

.....
Signature

.....
Name (printed)

.....
Date

This section must be completed by HR/Management

Investigation

Investigator:

Date:

Describe the incident,
hazard or the cause:

Hazard previously
identified:

☐ Yes ☐ No

How/when identified:

Action taken:

Control Measures Implemented

Risk assessment done: ☐ Yes ☐ No

Likelihood of incident
occurring again:

☐ Almost Certain ☐ Likely ☐ Possible ☐ Unlikely ☐ Rare

Consequence of
incident*:

☐ Catastrophic ☐ Major ☐ Moderate ☐ Minor ☐ Insignificant

Staff training required:

☐ Yes ☐ No

Comments:

Term	Definition
Notifiable Incident	Relevant state regulator (ie WorkSafe) must be notified immediately of any workplace incident that results in death or serious injury, or that exposes a person in the immediate vicinity to an immediate health or safety risk.
Serious injury	An injured person requires: - medical treatment within 48 hours of being exposed to a substance - immediate hospital treatment as an in-patient and/or immediate medical treatment for: amputation; serious head injury; spinal injury; serious eye injury; electric shock; loss of bodily function; serious laceration; separation of skin from underlying tissue (i.e. scalping)
Risk Assessment	Severity of injury: Catastrophic - Multiple staff or public affected debilitating injuries or fatalities or widespread medical attention required Major - Extensive effects, injuries, hospitalisation or single fatality Moderate - Significant effects needing management action. No fatalities Minor - Minor injuries requiring first aid but not immediate medical attention Insignificant - No injuries