FFS21 Incident / Injury Report Form

PART A—REGISTER OF INCIDENT/INJURY *Part A to be completed and submitted to the Institute within 24 hours.*					
Incident Type *(Please tick)*	☐ Injury / Illness	☐ Incident	☐ Near Miss		
Person Involved *(Please tick)*	☐ Employee	☐ Visitor	Contact Number:		
Person involved / Injured					
Name			☐ Female	☐ Male	
Date of Birth	____/____/_____		Contact Number:		
Occupation			Service Unit:		
Directorate			Company Name: _____		
Date and Time of Incident / Injury					
Date: _____/____/_____			Time: _____: _____	☐ AM	☐ PM
Details of Incident / Injury					
Did an injury occurred?	☐ No		☐ Yes		
Is injury a result of manual handling?	☐ No		☐ Yes		
Have you been inducted by trainer for manual handling risk assessment?			☐ No	☐ Yes	
Location of the Incident / Injury					
Description of the Incident / Injury *(How did it happen?)*					
Was there property damage?	☐ No		☐ Yes		
Description of the property damage					
Treatment					
☐ None	☐ Doctor	☐ Ambulance	☐ Hospital	☐ Police Notified	
Did you complete Work Cover Claim Form for the expenses or time lost?			☐ No	☐ Yes	

Witnesses			
Was the incident/injury witnessed?		☐ No	☐ Yes
If NO witnesses, was anyone in the vicinity when it occurred?		☐ No	☐ Yes
If YES, provide the witness details			
Witness 1	Name:	Contact Number:	
	Address:		
	Relationship to you:	Signature:	
Witness 2	Name:	Contact Number:	
	Address:		
	Relationship to you:	Signature:	

Acknowledgement	
Person completing this reporting form:	**RTO Representative:**
Signature:	**Signature:**
Printed Name:	**Printed Name:**
Date:	**Date:**

PART B—INVESTIGATION/ACTION TAKEN ***Part B to be completed by Manager/Supervisor***			
Name of Person Involved / Injured			
Date of Incident / Injured			
Time of Incident / Injured	____ : ____	☐ AM	☐ PM

Contributing Factors	
Equipment	☐ Defective Guarding ☐ Lack of Personal Protective Equipment ☐ Design ☐ Other (please specify) _____
Environment	☐ Weather ☐ Layout / Design ☐ Air Quality ☐ Other (please specify) _____

People	☐ Lack of Supervision ☐ Health ☐ Other (please specify) _____
Training *(Formal / On the job training)*	☐ Non prior training ☐ Needs Refresher ☐ In-adequate procedures ☐ In-adequate training ☐ Other (please specify) _____
Other Reason	
Final Solution	

Likelihood of Incident / Injury Re-Occurring			
How likely is the incident/injury likely to re-occur?	☐ Low	☐ Medium	☐ High
Reason			

Prevention Actions Taken *(Hierarchy of Control):* Can any of these controls be implemented?			
Elimination	Does the task have to be done?	☐ No	☐ Yes
	Reason:		
Substitution	Can a non-toxic product be substituted?	☐ No	☐ Yes
	Reason:		

Engineering	Does the task have to be done?	☐ No	☐ Yes
	Reason:		
Administration	Can we limit a person's exposure by rotating the task?	☐ No	☐ Yes
	Reason:		
Personal Protective Equipment	If any equipment needed such as Hearing Protection, Sunscreen etc.	☐ No	☐ Yes
	Reason:		

Action Taken to prevent Re-Occurrence

Action	By Whom	Date
		____/ ____/ _____
		____/ ____/ _____
		____/ ____/ _____
		____/ ____/ _____
		____/ ____/ _____

Acknowledgement of Preventive Actions Taken

Position	Print Name	Signature	Date
Manager			____/ ____/ _____
Supervisor			____/ ____/ _____

Forward completed incident/injury reporting form to the Risk Management Team

Management Use Only

☐ **Recorded on Incident Register by:** _____

☐ **Preventative Action Taken**

☐ **Work Cover Contacted by:** _____

☐ ***Worksafe Victoria Contact Details provided to all relevant parties: Contact Number 1800 136 089, email: worksafe.vic.gov.au.***

☐ **Procedure and Timeframe have been advised to all relevant parties**

Record Keeping

☐ ***HR Record keeping* by:** _____

☐ **Filling in the student file by:** _____