Title: Incident/Hazard Report Form		Applicable to: Centacare Community Services	
Date: 21st October 2014	No. of pages: 4	Last modified by: G.Somers	Authorised by: R. Littler

OFFICE USE ONLY

Date entered onto Incident/Hazard Register: / / 20 Incident Reference:

Work Health and Safety Incident / Hazard Report

If this is a Critical Incident, contact your Coordinator or Manager immediately.

Occurrence Type

☐ Injury / Illness	☐ Event / Near Miss (no injury sustained)	☐ Environment / Dangerous Goods
☐ Hazard	☐ Property / Equipment Damaged	☐ Third Party Injury (Other person)

Details of Person Involved in Incident / Hazard

Given Name:		Surname:	
Contact Number:		☐ Client ☐ Staff ☐ Member of Public	☐ Male ☐ Female
Service associated with:			

Details of Incident / Hazard

Date of Incident / Hazard:	/ / 20	Time: : ☐AM ☐PM
Location Address, e.g. 123 Sample Street Brisbane)		
Description of Incident / Hazard: Note: For all Client Behaviour and Critical Incidents: - Record a brief description (here) and provide reference to other completed documentation. **Immediate actions taken by Support Worker:**		

Other reports required

☐ Appendix A – Motor Vehicle Claim Form ☐ Appendix B – Behaviour Incident ☐ Appendix C – Medication Incident

Any other person / witness involved? ☐ Yes ☐ No	Name:	☐ Client ☐ Other:
Any other person / witness involved? ☐ Yes ☐ No	Name:	☐ Client ☐ Other:

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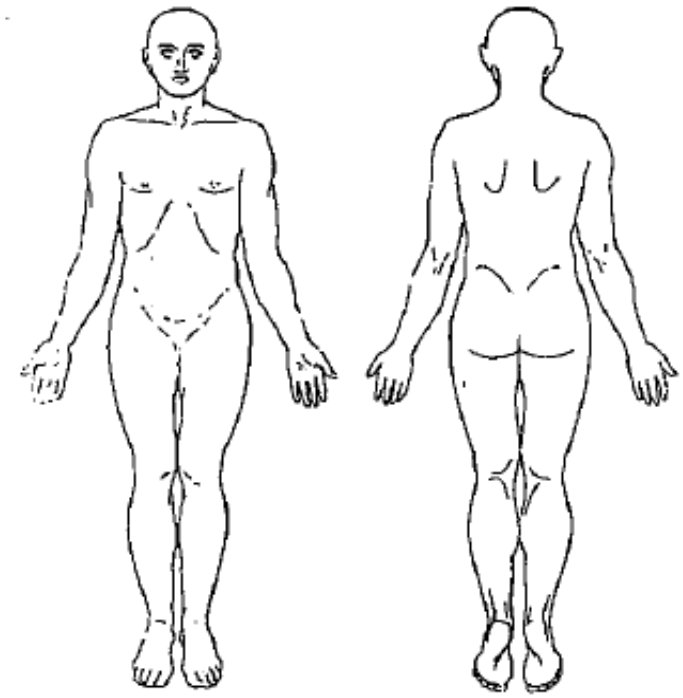
Injury / Illness

Was the person injured a staff member?	☐ Yes If yes, complete the below questions ☐ No If no, go to Injury Sustained
Person Injured: On the day of the incident, what time did you:	Start Work: : ☐AM ☐PM
	Finish Work: : ☐AM ☐PM
Did you have to leave the shift / workplace?	☐ Yes If yes, what time did you leave? : ☐AM ☐PM ☐No

Injury Sustained

Identify the location of the injury by **circling** on the diagram below:



- ☐ Allergic Reaction
- ☐ Asthma
- ☐ Blood nose
- ☐ Bruise / Crush
- ☐ Burn
- ☐ Concussion
- ☐ Dislocation
- ☐ Fainting
- ☐ Fractures / Broken bones
- ☐ Headaches
- ☐ Hernia
- ☐ Joint Damage
- ☐ Laceration / Cut / Abrasion
- ☐ Nausea
- ☐ Psychological / Stress
- ☐ Smoke inhalation
- ☐ Sprain or Strain (incl. Muscular / Body Stressing)
- ☐ Tendons / Carpel tunnel syndrome
- ☐ Vision Impairment
- ☐ Weather effects
- ☐ Whiplash

Treatment

☐ No treatment	☐ First Aid Details:
☐ Medical Treatment (e.g. Attend Doctor)	☐ Admission to hospital (in-patient) Name of hospital:

Reporting

Verbally reported to:			
Position:		Date:	/ / 20
Name of person completing report:			
Report completed on behalf of (if applicable):			
☐ I acknowledge this is a true representation of the incident / event.			
Signature:		Date:	/ / 20

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Incident / Hazard Report Service Action Sheet

Office Use Only – A timeframe of 24 hours applies for Critical and Notifiable Incidents

Incident / Hazard Report Form Received

☐ Appendix A – Motor Vehicle Incident	☐ Appendix B – Behaviour Incident	☐ Appendix C – Medication Incident	
Form/s received by:		Position:	
Signature:		Date:	/ / 20

Action Taken

☐ Phone contact with Injured Person, Decision Maker/ Next of Kin or Support Staff	By who:	
	Date:	/ / 20
☐ Personal contact with Injured Person, Decision Maker/ Next of Kin or Support Staff	By who:	
	Date:	/ / 20
☐ Complete incident investigation	By who:	
	Date:	/ / 20
☐ Corrective action implemented	By who:	
	Date:	/ / 20

Reported To

☐ Manager:	By who:	
	When:	
☐ WHS Unit Investigation Required: Note: Contact WHS Unit	By who:	
	By when:	
☐ WorkCover Claim Lodged: Note: Contact HR	Date lodged to HR:	/ / 20
	Claim Ref:	#

Basis of Employment (if worker injury)

☐ Full Time	☐ Permanent Part-time	☐ Casual	☐ Other:
☐ Volunteer	☐ Contractor	☐ Agency Staff	

Type / Nature of Work

☐ Administration	☐ Transport	☐ Food Handling
☐ Direct Client Services	☐ Maintenance / Home Safety	☐ Other:

Cause

- ☐ Absconding
- ☐ Assault by client
- ☐ Assault of: ☐ Staff ☐ Client ☐ Other
- ☐ Bites and Stings
- ☐ Bullying and Harassment (including sexual harassment)
- ☐ Childcare Playground Incident
- ☐ Client behaviour (1st incident or inadvertent injury)
- ☐ Contact with animal
- ☐ CCS – Use of physical restraint
- ☐ CCS – Use of chemical restraint
- ☐ CCS – Use of mechanical restraint
- ☐ CCS – Restricting access to objects
- ☐ Exposure to chemical / other substance
- ☐ Hitting stationary objects
- ☐ Hit by moving object
- ☐ Infection / Control / Hygiene (eg. biological substance)
- ☐ Manual Handling
- ☐ Medical Condition
- ☐ Medication Error
- ☐ Operating Equipment
- ☐ Other child safety event
- ☐ Self-Harm
- ☐ Slips, Trips and Falls (including falls from heights)
- ☐ Damage, Theft or Loss of Property or Equipment
- ☐ Thermal (Hot/Cold), Radiation or Electrical Exposure
- ☐ Vehicular Accident
- ☐ Wheelchair Accident

What is worker's capacity for work?

☐ Returned to pre-injury duties ☐ Restricted work injury (Suitable Duties) ☐ Lost time injury (Not able to work)

Preventative Action Required

Attach all additional case notes and results of investigation/s to this Incident / Hazard Report Form when completed.	☐ Change Work Environment	☐ Performance Management
	☐ Additional Training Required	☐ Equipment / Resources Required
	☐ Change Work Procedure	☐ Modify Equipment

Date	Action taken	Outcomes
/ / 20		
/ / 20		
/ / 20		
/ / 20		
/ / 20		
/ / 20		

Has this incident been identified as a critical Incident?		☐ Yes ☐ No	
Manager name:			
Signature:		Date:	/ / 20