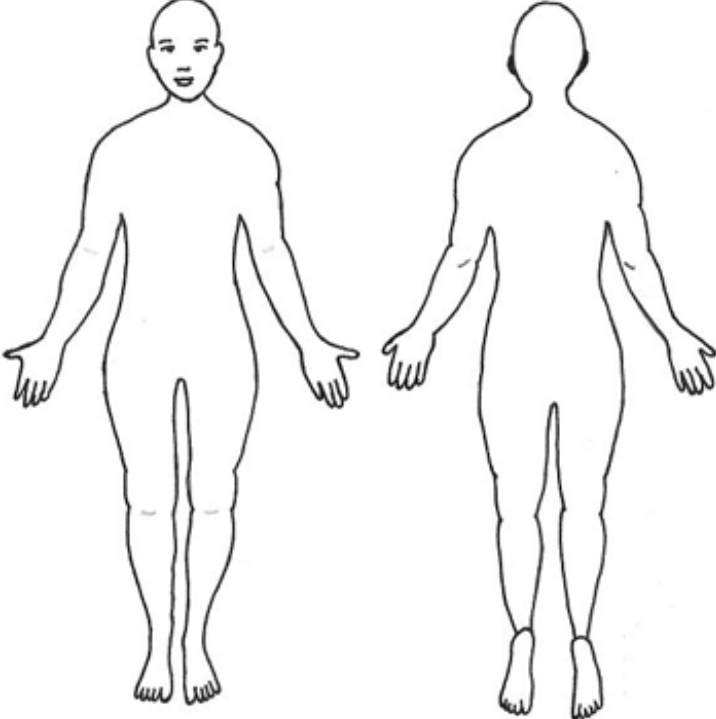


PART A – Details of incident

Details of person involved/injured	Name: _____	
	Address: _____	
	Contact No: _____	Email address: _____
	Section/Dept: _____	
	<input type="checkbox"/> Staff <input type="checkbox"/> Visitor <input type="checkbox"/> Contractor <input type="checkbox"/> Public <input type="checkbox"/> Client <input type="checkbox"/> Other	
Date/time of incident	____ / ____ / ____ ____ : ____ AM/PM	
Location of incident	_____	
Type of Incident	<input type="checkbox"/> Personal Injury <input type="checkbox"/> Near Miss <input type="checkbox"/> Hazard <input type="checkbox"/> Property/Vehicle Damage <input type="checkbox"/> Vehicle Accident <input type="checkbox"/> Other	
Activity being undertaken when Incident Occurred	_____ _____ _____	
Brief description of incident	_____ _____ _____	
Any witnesses? Who?	_____	

PART B – Details of injury (if applicable)

Nature of Injury (indicate all relevant) Circle Location of Injury(s) <i>(Use the comment tools to highlight sections.</i> <i>Alternatively, print the form and draw manually.)</i>	
Description of Injury(s)	_____ _____ _____
Treatment required (highest level only)	<input type="checkbox"/> No treatment required <input type="checkbox"/> First Aid <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital outpatient <input type="checkbox"/> Hospital admission <input type="checkbox"/> Ceased Work <input type="checkbox"/> Refused Treatment First Aider Name: _____ Signature: _____

PART C – Reporting

Who was the Incident Reported to?	To: _____ Date: ____/____/____ ____:____AM / PM <input type="checkbox"/> Manager/Team Leader <input type="checkbox"/> Health & Safety Representative <input type="checkbox"/> OHS & Risk Officer Do you consent to the Health and Safety Representative being notified of this Incident? <input type="checkbox"/> Yes <input type="checkbox"/> No
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PART D – Recommendations/Actions

Person involved recommendations	_____ _____ _____
Managers Recommendations	<input type="checkbox"/> Elimination: _____ <input type="checkbox"/> Substitution: _____ <input type="checkbox"/> Isolation: _____ <input type="checkbox"/> Engineering: _____ <input type="checkbox"/> Administrative: _____ <input type="checkbox"/> Personal protective equipment: _____ <u>Further explanation (if required):</u> _____ _____ _____ <u>Do you believe further investigation is required with the OHS, Risk Officer?</u> <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please specify why: _____ _____

PART E – Confirmation & Acknowledgement

I declare that all the information contained in this report is, to the best of my knowledge, true and correct.

Name: _____ Signature: _____ Date: ____/____/____

Confirmation of Receipt of Report (Team Leader/Manager/HSR)

Name: _____ Signature: _____ Date: ____/____/____

Does the First Aid Kit require replenishment?	<input type="checkbox"/> Yes <input type="checkbox"/> No Items used: _____
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Privacy statement

Personal information collected by Council is held securely and used in accordance with the **Privacy and Data Protection Act 2014**. Council may disclose this information to other organisations if required or permitted by legislation. Should you wish to access or modify this information, please contact Council on [\(03\) 5494 1200](tel:0354941200) or email OHS@loddon.vic.gov.au * N.B. Actions are usually coordinated by the supervisor/manager.

Office use only: WHSMS LCM Injury notification Yes NA Date Entered: ____/____/____ Signature: _____