

PFS21 Incident / Injury Report Form

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

Witnesses			
Was the incident/injury witnessed?		<input type="checkbox"/> No	<input type="checkbox"/> Yes
If NO witnesses, was anyone in the vicinity when it occurred?		<input type="checkbox"/> No	<input type="checkbox"/> 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 <i>Part B to be completed by Manager/Supervisor</i>			
Name of Person Involved / Injured			
Date of Incident / Injured			
Time of Incident / Injured		___ : ___	<input type="checkbox"/> AM <input type="checkbox"/> PM
Contributing Factors			
Equipment	<input type="checkbox"/> Defective Guarding <input type="checkbox"/> Lack of Personal Protective Equipment <input type="checkbox"/> Design <input type="checkbox"/> Other (please specify) <hr/>		
Environment	<input type="checkbox"/> Weather <input type="checkbox"/> Layout / Design <input type="checkbox"/> Air Quality <input type="checkbox"/> Other (please specify) <hr/>		

People	<input type="checkbox"/> Lack of Supervision <input type="checkbox"/> Health <input type="checkbox"/> Other (please specify) <hr/>		
Training (Formal / On the job training)	<input type="checkbox"/> Non prior training <input type="checkbox"/> Needs Refresher <input type="checkbox"/> In-adequate procedures <input type="checkbox"/> In-adequate training <input type="checkbox"/> Other (please specify) <hr/>		
Other Reason			
Final Solution			
Likelihood of Incident / Injury Re-Occurring			
How likely is the incident/injury likely to re-occur?	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High
Reason			
Prevention Actions Taken (Hierarchy of Control): Can any of these controls be implemented?			
Elimination	Does the task have to be done?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Reason:		
Substitution	Can a non-toxic product be substituted?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Reason:		
	Does the task have to be done?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Engineering	Reason:		
Administration	Can we limit a person's exposure by rotating the task?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Reason:		
Personal Protective Equipment	If any equipment needed such as Hearing Protection, Sunscreen etc.	<input type="checkbox"/> No	<input type="checkbox"/> 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			
<input type="checkbox"/> Recorded on Incident Register by: _____ <input type="checkbox"/> Preventative Action Taken <input type="checkbox"/> Work Cover Contacted by: _____ <input type="checkbox"/> Worksafe Victoria Contact Details provided to all relevant parties: Contact Number 1800 136 089, email: worksafe.vic.gov.au. <input type="checkbox"/> Procedure and Timeframe have been advised to all relevant parties			
Record Keeping			
<input type="checkbox"/> HR Record keeping by: _____ <input type="checkbox"/> Filing in the student file by: _____			