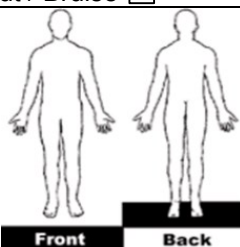
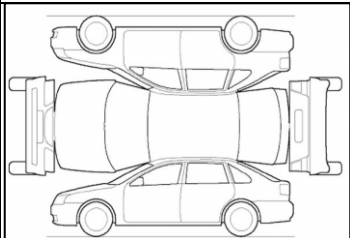


# INCIDENT REPORT FORM

This form must be completed for an incident involving injury/illness, property/environmental damage, motor vehicle accidents, hazards or near misses, and to be reported to HR as soon as possible.

**All Major and Severe incidents or incidents requiring notification to WorkSafe must also be reported immediately to the OSH Advisor on Ph. 08 6820 3115 or Mob. 0447880771.**

STEP 1. CITY OF ALBANY EMPLOYEE TO COMPLETE STEPS 1 - 5			
Your Name:	Job Title:		
Reported to:	Job Title:		
Injured Party Name and Title:			
Employee <input type="checkbox"/> Volunteer <input type="checkbox"/> Contractor <input type="checkbox"/> Visitor <input type="checkbox"/> Other <input type="checkbox"/> (Please Specify e.g. Public):			
Date/Time <b>Occurred:</b>	Date:	Time:	
Date/Time <b>Reported:</b>	Date:	Time:	
Worksite: (e.g. North Road Admin Off Site, ALAC Courts, Depot Workshop)			
STEP 2. DETAILS OF INVOLVED PARTYS (Names, Position Titles, Contact Details and Address for Witnesses)			
STEP 3. DETAILS OF INCIDENT			
Hazard <input type="checkbox"/> Near Miss <input type="checkbox"/> Property Damage <input type="checkbox"/> Injury / Illness <input type="checkbox"/> Emergency Services Involved <input type="checkbox"/>			
Brief Description of Incident, Hazard or Damage (What Happened? Where? How? Who? Why? Causal Factors? E.G. Slipped in Puddle Caused by Hole in the Roof)			
STEP 4. DETAILS OF MEDICAL ATTENTION			
First Aid Provided <input type="checkbox"/>	Employee to Miss Time at Work <input type="checkbox"/>	Medical Provider:	
Slip / Fall <input type="checkbox"/>	Object in Eye <input type="checkbox"/>	Sprain / Strain <input type="checkbox"/>	Cut / Bruise <input type="checkbox"/>
Detailed Description of the Injury/Illness and Medical Attention to the Specific Part of the Body:			
			
Obtained a First Medical from Doctor / Hospital <input type="checkbox"/>	Completed the Workers Compensation Form <input type="checkbox"/>	Obtained Letter Outlining Claim <input type="checkbox"/>	Handed Documents to your Manager / Supervisor for Processing <input type="checkbox"/>

STEP 5. DETAILS OF PROPERTY / VEHICLE / PLANT DAMAGE (For Depot Heavy Plant Please Also Fill out Report Book in Workshop)			
Plant (Please Specify Plant Numbers) <input type="checkbox"/>			
Property Damage (Please Specify i.e. Fence) <input type="checkbox"/>			
Motor Vehicle <input type="checkbox"/>	Make:	Model:	Colour:
Registration Number:	License:	Class:	Expiry Date:
Description of Damage: (Please Follow Fleet Management Guidelines Specifically Annexure P Form, take photos of any damage, and complete the online police report if a third party is involved at <a href="https://www.crashreport.com.au/ocrf/">https://www.crashreport.com.au/ocrf/</a> , as well as report the incident / accident to Risk Management Officer on 98419347)			Police Report No:
			

**TO BE COMPLETED BY MANAGER/SUPERVISOR WITH OSH REPRESENTATIVE**

**STEP 6. INVESTIGATION**

Investigation Results (What is the Hazard? Risk? Root Cause? E.G. Maintenance of Facilities):

Incident Requiring Worksafe Notification       Attached Completed Public Liability Claim Form

**STEP 7. RISK ASSESSMENT**

Likelihood and Consequences Risk Matrix (Please place an X in the Box)			Consequences				
			Insignificant	Minor	Moderate	Major	Severe
			No treatment required	Basic first aid treatment	Medical treatment (ambulance / hospital)	Extensive injury	Fatality / severe permanent disability
Likelihood	<b>Almost Certain</b>	Occurring more than 10 times per year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Likely</b>	Occurring greater than once per year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Possible</b>	Occurring less than once per year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Unlikely</b>	Occurring less than once every 10 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Rare</b>	Occurring less than once every 50 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Low</b> Report to Manager and controls to be monitored		<b>Medium</b> Report to Manager for <b>Minor</b> Investigation	<b>High</b> Report to Manager for <b>Formal</b> Investigation, Action and Control		<b>Extreme</b> Report to Manager for <b>Immediate External</b> Investigation, do not start work		

**STEP 8. CORRECTIVE ACTIONS**

(Control to be Implemented with Subsequent Risk Rating, Time Frame and Responsible Person)

Hierarchy of Controls	<b>Elimination</b> (Physically remove the hazard)	
	<b>Substitution</b> (Replace the hazard)	
	<b>Engineering Controls</b> (Isolate people from the hazard)	
	<b>Administrative Controls</b> (Change the way people work)	
	<b>PPE</b> (Protect the worker with PPE)	

Manager / Supervisor Name and Signature:	Date:
Safety Representative Name and Signature:	Date:
Reporting Employee Name and Signature:	Date:

**OFFICE USE ONLY**

Synergy No:	Incident No:	Incident/Accident/Hazard No:
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