

# Accident/Incident Reporting Form

## Person Completing this Form

First Name:	Surname:
Preferred contact number:	Position Title/Level:
Signature: _____ Date: ___/___/___	

## Person Affected

**Status of Person Affected:** *(please circle/provide detail)*

**ACT Government Employee**      **Volunteer Emergency Worker**      **Third Party:** \_\_\_\_\_

First Name:	Surname:
Relevant Agency:	Brigade/Unit:
Preferred Contact Number:	Gender:
Email Address:	

## When did it occur?

Date and Time of Event:	___:___am/pm	___/___/___
Duty Officer/Supervisor Name:		
Date and Time Duty Officer Notified:	___:___am/pm	___/___/___

## Where did it occur?

Where did the Incident/Accident Occur? <i>(inc. Map reference, street address etc)</i>	
Exact Location of the Incident/Accident? <i>(Shed, Truck, Fireground, Roof, etc)</i>	

## What happened?

Summary of Incident/Accident: <i>(inc. details on the outcome of the Incident/Accident)</i>	
Impact of Incident/Accident: <i>(at time of reporting)</i>	Was this a near miss? ..... <input type="checkbox"/> No injury or illness, it was a hazardous situation? ..... <input type="checkbox"/> Minor injury or illness, no time was lost as a result? ..... <input type="checkbox"/> Less than one day of lost work? ..... <input type="checkbox"/> One day or more of lost work? ..... <input type="checkbox"/>

# Accident/Incident Reporting Form

## Violence/Bullying/Harassment/Discrimination

Was Violence/Abuse Involved?	Y / N	Was Bullying/ Harassment Involved?	Y / N	Was Discrimination Involved?	Y / N
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If 'Yes' to any of the above, please provide detail:

## Background to Task

Task Being Performed:  
*(inc. lead up actions and specific details of task.)*

Was Incident/Accident related to task?	Y / N	Experience in performing task?	Yrs: _____ Mths: _____	Trained in task?	Y / N	Was appropriate Personal Protective Equipment required/worn?	Y / N
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## Corrective Actions

Were any short term corrective or preventative actions taken?	Y / N	If 'Yes', please provide detail:
Are any long term preventative actions required? <i>(inc. Training)</i>	Y / N	If 'Yes', please provide detail:

## Witness

First Name:	Surname:
Position Title:	Preferred Contact Number:

## Person Supervising at Time of Incident

First Name:	Surname:
Position Title:	Preferred Contact Number:

## Form entered into RISKMAN by

First Name:	Surname:
Preferred contact number:	Position Title/Level:

Is this Incident/Accident a WorkSafe Notifiable Event? *(please circle)* Y / N

Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

## Privacy Notice:

The information in this form is collected to comply with the ACT Government's responsibilities for recording workplace accidents/incidents and in accordance with *Work Health and Safety Act 2011* as well as:

- The *Privacy Act 1988 (Cwth)*. The Privacy Act entitles you to check the record processed from the information you have provided and to correct any inaccuracies.
- The *ACT Health Records (Privacy and Access) Act 1997* which outlines the rights of access to records and how they are kept.

The information in this form will only be disclosed to those who have authorisation to receive the information unless written permission is obtained from the person involved.