FEDERATION COUNCIL

INCIDENT REPORT FORM

Incident Type √: Incident ☐ Injury ☐ Illness ☐ Near Miss ☐ Hit Services ☐

Person reporting							
First name		Last name					
D.O.B		Department/team		Payroll No			
				Position			
Gender Male ☐ Female☐	Address (if volunteer or member of public)	Street					
		City		Post Code			
		State		Phone			
Signature of person reporting		Time		am/pm	Date		

(If insufficient space, please attach further information to report)

Incident / Injury / Illness / Near Miss / Damaged Services details						
Date of incident:		**Time of incident**		am/pm		
Nature of incident	**Incident**	**Injury**	**Illness**	**MVA**	**Near Miss**	**Damaged Services**
Details of Incident / Injury / Illness (include symptoms)						
Location where incident occurred						
Was any plant or vehicle involved in the incident?				Yes		No
Make		Reg No		Plant No		
Damage				Towed	Yes	No
Driver (as above if person reporting)		List other vehicles or objects involved. Use separate sheet If needed				
Were there any witnesses to the incident?				Yes		No
Name				Phone		
Name				Phone		
Name				Phone		
Has the injury been reported to the worker's Supervisor?				Yes		No
Reported to		Time		am/pm	Date	
If not reported please explain why?						

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Details of person making this entry if different to person reporting:					
First Name		Last name			
Position		Department			
Signature		Date			
Did you witness incident?			Yes	No	

To be completed by Manager/Supervisor of person reporting:								
Was any treatment provided? If yes, please provide details:						Yes	No	N/A
First Aid	Yes	No	Ambulance	Yes	No	Hospital o/night	Yes	No
Additional information:								
Did the injured worker return to work following the injury/illness? If yes, please provide details:						Yes	No	N/A
Will / has an investigation be/been conducted into the incident?						Yes	No	
Investigation Report:								
What controls have been implemented to ensure the incident doesn't happen again:								
Name		Position		Signature		Date		

To be completed by Risk Management Staff:					
Name:				Hereby confirm receipt of this notification	
Signature:		Date:		HPCM No:	
Notifications:	Statewide ☐ StateCover ☐	SafeWork NSW ☐ RMS ☐	Fire /Hazmat ☐ Police ☐	Water □ Gas □ Electricity □	
Actions:	Public Liability	Motor Vehicle Claim	Workers Compensation	Other	
Additional actions or notifications pending:					