Insert your logo here

**Accident/Incident/Early Reporting Form**

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| --- | --- | --- | --- |
| **Work Area / Department** | Time of Incident hh:mm pm / am  Time started Shift hh:mm pm / am | Incident Date dd/mm/yyyy Date of Report dd/mm/yyyy | Injured Employee Name : Enter here  Date of birth dd/mm/yyyy: |
| **First Aider (write name clearly)** | Witness | **TREATMENT** (Tick appropriate box) Nil 🞎 First Aid 🞎 Doctor 🞎 Hospital 🞎 | |
| **STATUS** (tick appropriate box) Permanent 🞎 Fixed Term 🞎 Contractor 🞎 Other 🞎 (please state) | | | |
| **Severity:**   1. **Sever pain** 2. **Pain** 3. **Mild pain** 4. **Discomfort**   **Duration**   1. **Discomfort/Pain is always present to some degree** 2. **Discomfort/pain stays after work but improves after a night’s rest** 3. **Only at work** 4. **Occasional**   **Severity Scale**  Enter here  **Duration Scale**  Enter here    **Discomfort/Injury Type (tick)**  **Discomfort/Injury Details – Body Part** | | 1. **Description of Accident / Incident: (please describe your interpretation of events)**   Enter here | |
| 1. **Information for Discomfort for Early Reporting:**  * - When did you first notice discomfort / pain? * - Is it getting worse, better or staying the same? * - Have you had this discomfort/pain before? * - What are you doing to help relieve the discomfort/pain? * - Is there anything else you feel we should know? (note on reverse) | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Root Cause(s) of Incident** | **Initial Control/Corrective Action**  **Suggested Action/s** | **Person Responsible for completing** | **Date Completed** | **Review Completed** | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | | |
| Is Further Investigation Required? Yes 🞎 No 🞎 (If no, please give reason):  Final Classification: Early Discomfort Incident (EDI) 🞎 / Near Miss Incident (NMI) 🞎 / First Aid Incident (FAI) Medical Treatment Incident (MTI) 🞎 / Lost Time Incident (LTI) 🞎  Department Manager Sign off: Date:  Initiator Sign off: Date:  Other Sign off eg Health & Safety Committee:  Yes 🞎 No 🞎 Date: | |