Insert your logo here

**Accident/Incident/Early Reporting Form**

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| **Work Area / Department** | Time of Incident hh:mm pm / amTime started Shift hh:mm pm / am | Incident Date dd/mm/yyyyDate of Report dd/mm/yyyy | Injured Employee Name : Enter hereDate 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)
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| --- | --- | --- | --- | --- |
| **Root Cause(s) of Incident** | **Initial Control/Corrective Action****Suggested Action/s** | **Person Responsible for completing** | **Date Completed** | **Review Completed** |
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| 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:  |