

Location Of Injury (if applicable) (Circle the most appropriate)		
Head/Face	Eyes	Internal Organs
Hands/Fingers	Shoulders/Arms	Trunk (other than back)
Hip/Leg	Foot/Toes	Back
Other (please specify) _____		

Results Of Accident		
Lost Time Injury Y / N	No. of Days: _____ days	Workers Comp Y / N
Treatment Received: First Aid Doctor Hospitalisation (Please Circle)		

Damage To Equipment/Buildings/Vehicles etc.
What was damaged? _____
Extent of damage? _____

Contributing Factors (if any) (Consider factors such as Environmental, Equipment failure, Training, Procedural)

Corrective Actions	
(Should be completed in conjunction with Manager/Supervisor with due regard to hierarchy of controls i.e. Elimination, Substitution, Engineering, Isolation, Administrative & PPE)	
Immediate Actions	
Recommendations to prevent a future recurrence of this incident	
Person Responsible for Implementation	
Target Date For Completion	

Finalisation Signatures	
Worker: _____	Date: _____
HS Rep: _____	Date: _____
Manager: _____	Date: _____