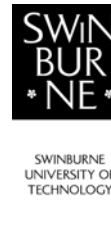


Section A: Incident / Hazard Report



SERIOUS INCIDENTS MUST BE REPORTED BY PHONE IMMEDIATELY TO THE OH&S CONSULTANT 0404 006 987
 (Speed dial 3188)
 SECTIONS A & B OF THIS REPORT MUST BE FAXED TO HR WITHIN 48 HOURS ON: 03 9214 8565
 IF A MANAGEMENT RESPONSE IS NOT ESTABLISHED AT TIME - FAX SECTION C AS SOON AS POSSIBLE

1. PERSON INVOLVED DETAILS – FORWARD TO YOUR TEAM LEADER / MANAGER WITHIN 24 HOURS

Given name:	Position Title:	<input type="checkbox"/> Employee
Family name:	Employee number / Student ID:	<input type="checkbox"/> Swinburne Student
Address:	Division:	International? Y <input type="checkbox"/> N <input type="checkbox"/>
	Management Unit:	<input type="checkbox"/> Visiting Student
	TAFE Unit / Sub Management Unit:	<input type="checkbox"/> Agency Personnel
DOB: Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Contact details: BH AH:	<input type="checkbox"/> Visitor
		<input type="checkbox"/> Contractor
Have you reported this to your Team Leader / Manager / Teacher? <input type="checkbox"/> Yes <input type="checkbox"/> No Date notified:		
Name (please Print):		Contact no:

2. DETAILS OF INCIDENT / HAZARD

Act of Violence Injury / Illness* Incident / Near Miss Hazard Property Damage

*If you are reporting a work related injury / illness please also complete [Section B](#) of this form

Campus:	Area: (building / room):	Date hazard observed / incident occurred:
Off-Site (specify location):		Time:
What were you doing? Describe the activity undertaken at the time		
What happened unexpectedly? Describe the hazard / incident as it occurred		
What did you do? Describe what happened next		
What factors do you feel caused this hazard / incident?		

3. WERE THERE ANY WITNESSES? YES NO

Name:	Contact Phone number:
Name:	Contact Phone number:

4. SIGNATURE OF PERSON MAKING REPORT

Print name of person making report	Name	Date
	Signature	Contact no:
Print name of Team Leader / Manager / Manager's nominated representative confirming receipt of report	Name	Date
	Signature	

Section B: Report of Injury or Illness / First Aid Record

5. COMPLETE ONLY IF INJURY / ILLNESS SUSTAINED

Description of Injury / medical condition

Is this an aggravation of a previous injury or condition? Yes No Not Known

Initial Treatment

Nil First aid officer Campus Nurse Security

Name:

Status of person at time of completing report

Resumed full hrs work / study
 Ceased work / study
 Partial return work / study
 Returned to alternate duties

Has the injury resulted in loss of work hours?

Yes No

Time lost: **hour/s**

Time lost: **days**

To be completed by First aid officer / Campus Nurse / Security

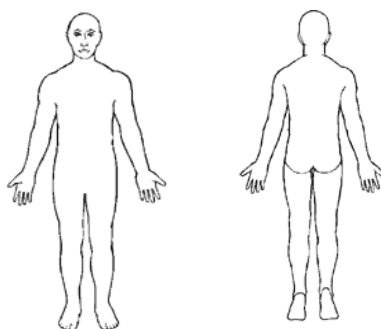
Observations: Unconscious Altered Conscious Conscious

Breathing: Slow Normal Fast

Skin Colour: Pale Normal Flushed

Other observations:

Assessment:



Follow up (if known)

Medical Treatment by Health Professional

Name / Dr.....

Ambulance / Hospital

Inpatient Outpatient

Name of Hospital

.....

TYPE OF INJURY

Amputation
 Bruise
 Burns
 Cut / Laceration
 Dislocation
 Foreign body
 Fracture
 Grazes, scratches/ abrasions

Head injury
 Heat stress / exhaustion
 Internal injury
 Poisoning / toxic effects of substance
 Sprains / strains
 Other (please specify)

TYPE OF DISEASE

Allergic reaction
 Dermatitis / Exzema
 Disease of circulatory system
 Disorders of the muscles, tendons & soft tissues
 Eye Disorders
 Hearing loss
 Hernia

Infectious / Parasitic
 Loss of consciousness – fainting, seizure
 Psychological
 Respiratory irritation / disease
 Other diseases (please specify)

BODILY LOCATION OF INJURY - Indicate left or right as appropriate as L or R next to body part

Head
 Face
 Eyes
 Ear
 Nose
 Mouth
 Head – multiple locations

Neck
 Back upper
 Back lower
 Chest
 Abdomen
 Groin / pelvic region
 Trunk – multiple locations

Shoulder
 Upper arm
 Elbow
 Forearm
 Wrist
 Hands, fingers & thumb
 Upper limb – multiple locations

Hip
 Leg upper
 Knee
 Leg lower
 Ankle
 Foot / toes
 Lower limb – multiple locations

Name of injured person (please print)

Signature

Date

If not injured person Name: (please print)

Signature

Date

Name Team Leader / Manager / Manager's nominated representative confirming receipt of report (please print)

Signature

Date

Section C: Incident / Hazard Investigation & Control

Please ensure Section C "Incident / Hazard Investigation form is completed and faxed through to OHS when investigation completed

Is this a serious incident? If yes – contact OHS consultant immediately on 0404 006 987

Refer - http://www.swinburne.edu.au/corporate/hr/ohs/ohs_incident_reporting.htm

6. INCIDENT INVESTIGATION – TO BE UNDERTAKEN BY TEAM LEADER / MANAGER / MANAGER'S NOMINATED REPRESENTATIVE.

If the incident was caused by a criminal act, have the Police been notified? Yes No N/A

Has a work order been logged with Facilities in relation to this report? Yes No N/A

If yes give job number:

Has a health & safety representative been consulted in relation to this report? Yes No

Name:

What were the factors that may have led to the incident/hazard (there may be more than one). Consider areas below.

System	No <input type="checkbox"/>	Yes <input type="checkbox"/> see below	Plant / Equipment	No <input type="checkbox"/>	Yes <input type="checkbox"/> see below	Environment	No <input type="checkbox"/>	Yes <input type="checkbox"/> see below	People	No <input type="checkbox"/>	Yes <input type="checkbox"/> see below
Procedures	<input type="checkbox"/>	<input type="checkbox"/>	Size/ weight	<input type="checkbox"/>	<input type="checkbox"/>	Access	<input type="checkbox"/>	<input type="checkbox"/>	Supervision	<input type="checkbox"/>	<input type="checkbox"/>
Workload	<input type="checkbox"/>	<input type="checkbox"/>	Design	<input type="checkbox"/>	<input type="checkbox"/>	Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	Training	<input type="checkbox"/>	<input type="checkbox"/>
Maintenance	<input type="checkbox"/>	<input type="checkbox"/>	Maintenance	<input type="checkbox"/>	<input type="checkbox"/>	Lighting	<input type="checkbox"/>	<input type="checkbox"/>	Job competency	<input type="checkbox"/>	<input type="checkbox"/>
Task allocation	<input type="checkbox"/>	<input type="checkbox"/>	Chemicals	<input type="checkbox"/>	<input type="checkbox"/>	Weather/ Temperature	<input type="checkbox"/>	<input type="checkbox"/>	PPE not used	<input type="checkbox"/>	<input type="checkbox"/>
Audits	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	Floor / ground surface	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify).....	<input type="checkbox"/>	<input type="checkbox"/>	specify.....	<input type="checkbox"/>	<input type="checkbox"/>	Other specify	<input type="checkbox"/>	<input type="checkbox"/>	specify.....	<input type="checkbox"/>	<input type="checkbox"/>

Any other observations / comments from Manager.

7. RISK ASSESSMENT

Risk Assessment – What is the worst possible consequences of this hazard / incident?

What is the likelihood of this occurring?

RISK RATING CONSEQUENCE	LIKELIHOOD				
	Rare The event will only occur in exceptional circumstances	Unlikely The event is not likely to occur in a year	Possible The event may occur within a year	Likely The event is likely to occur within a year	Almost Certain The event is almost certain to occur within a year
Catastrophic (Accidental death / serious injury)	Significant Risk	Significant Risk	High Risk	High Risk	High Risk
Major (Serious injury)	Low Risk	Moderate Risk	Significant Risk	High Risk	High Risk
Moderate (Lost time due to workplace injury)	Low Risk	Low Risk	Moderate Risk	Significant Risk	High Risk
Minor (Minor workplace injury – no lost time)	Low Risk	Low Risk	Low Risk	Moderate Risk	Significant Risk
Minimal (No injury)	Low Risk	Low Risk	Low Risk	Low Risk	Moderate Risk

Risk Rating for this hazard / incident – tick one as appropriate:

High Risk		Significant Risk		Moderate Risk		Low Risk	
Immediate action required	<input type="checkbox"/>	Action required as soon as possible	<input type="checkbox"/>	Action required within 1-3 months	<input type="checkbox"/>	Monitor the hazard Minimal action	<input type="checkbox"/>

Section C: Incident / Hazard Investigation & Control

8. RISK CONTROL/S – THIS SECTION MUST BE COMPLETED AND FAXED TO OHS ONCE ACTIONS AGREED

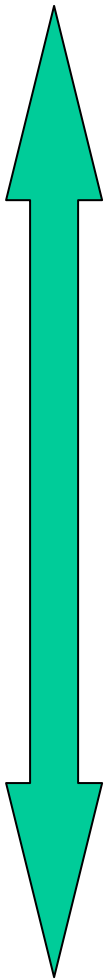
List any short term actions that have been implemented to control the risk of a repeat:

What further actions need to be taken to control the risk?

(If risk control not relevant please indicate N/A in relevant box)

Note: When identifying appropriate controls, you should start at the top of the hierarchy (try to **eliminate** the hazard first).

If that is not possible, then one of the other control measures or a combination of them will be necessary.

	Risk Control	Action to be taken	By whom	By when
	Elimination Eg. Discontinue use of product, equipment, cease work process			
	Substitution Eg. Replace with a similar item that does the same job but with a lower hazard level			
	Isolation Eg. Put a barrier between the person and the hazard			
	Engineering controls Eg. Change the process, equipment or tools so the risk is reduced			
	Administration controls Eg. Guidelines, procedures, rosters, training etc to minimise the risk			
	Personal protective equipment Eg. Equipment worn to provide a temporary barrier			

Investigation completed by Team Leader / Manager / Manager's nominated representative :

Print Name:

Management Unit:

Position Title:

Phone:

Signature:

Date:

Document Distribution:

- 1) Fax all completed forms within 48 hours to OH&S Consultant 9214-8565
- 2) Original forms to be kept on-site in the Register of Injuries folder for a minimum of 5 years