

<b>ACCIDENT/INCIDENT CLASSIFICATION:</b>			
Fatality <input type="checkbox"/>		Lost Time Injury <input type="checkbox"/>	
Medical Treatment Injury <input type="checkbox"/>		First Aid Injury <input type="checkbox"/>	
Notification Only <input type="checkbox"/>		Property Damage <input type="checkbox"/>	
<b>CLAIM LODGED</b> Please indicate if this will result in a workers compensation claim being lodged Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>Did this accident/incident occur during overtime?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>DATE &amp; TIME OF OCCURRENCE:</b>			
Date (d/m/yr): ____/____/____		Time: ____-____ am/pm	
<b>COMPANY NAME</b> (Working at)		<b>WORK LOCATION</b>	
		<b>SUPERVISOR/MANAGER</b> (Print name)	
<b>EMPLOYEE NAME</b>		<b>SEX</b>	<b>OCCUPATION</b>
First Name:	Surname:	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Employee Address:	Postcode:	D.O.B Date (d/m/yr): ____/____/____	
Employee Telephone: (H)	(M)		
<b>SERVICE DATE</b> (START DATE WITH CHOICE HR) (d/m/y) ____/____/____		<b>DATE EMPLOYER NOTIFIED OF INCIDENT</b> (d/m/y) ____/____/____	
<b>TYPE OF INJURY</b> (Cut, Strain, Fracture, Skin Rash, etc) TICK THE TYPE OF INJURY SUSTAINED		<b>PART OF BODY INJURED</b> (back, left wrist, right eye, etc)	
<input type="checkbox"/> AMPUTATION <input type="checkbox"/> ABRASION <input type="checkbox"/> BURN <input type="checkbox"/> SPRAIN/STRAIN <input type="checkbox"/> BRUISE <input type="checkbox"/> LACERATION/CUT <input type="checkbox"/> CONCUSSION <input type="checkbox"/> DISLOCATION <input type="checkbox"/> FOREIGN BODY <input type="checkbox"/> FRACTURE <input type="checkbox"/> SUSPECTED INTERNAL INJURY <input type="checkbox"/> POISONING <input type="checkbox"/> SUSPECTED SPINAL INJURY		<input type="checkbox"/> ARM (L / R) <input type="checkbox"/> CHEST (L / R) <input type="checkbox"/> SHOULDER (L / R) <input type="checkbox"/> GROIN <input type="checkbox"/> BACK - LOWER (L / R) <input type="checkbox"/> BACK - UPPER (L / R) <input type="checkbox"/> NECK (L / R) <input type="checkbox"/> FOOT/ANKLE (L / R) <input type="checkbox"/> HAND/WRIST (L / R) <input type="checkbox"/> STOMACH <input type="checkbox"/> FACE (L / R) <input type="checkbox"/> HEAD (L / R) <input type="checkbox"/> EYES (L / R) <input type="checkbox"/> KNEE/LEG (L / R) <input type="checkbox"/> OTHER (PLEASE SPECIFY)	
<b>EXACT LOCATION OF ACCIDENT/INCIDENT:</b> (Office, Storeroom, etc)			
<b>WITNESS NAME(S):</b>			
<b>WHAT WAS EMPLOYEE DOING WHEN INJURY OCCURRED?</b> (Please be specific. Identify tools, equipment or material the employee was using)			
<b>HOW DID THE ACCIDENT/INCIDENT/EXPOSURE OCCUR?</b> (Describe fully the events that resulted in the accident/incident describe what happened and how it happened use separate sheet of paper if necessary)			
<b>WHERE WERE INJURIES TREATED?</b> (i.e. name of clinic or location)		<b>IF SENT TO DOCTOR OR HOSPITALISED, NAME &amp; LOCATION OF DOCTOR/HOSPITAL</b>	
<b>TREATMENT GIVEN? YES OR NO (IF YES PLEASE SPECIFY THE TYPE OF TREATMENT ADMINISTERED)</b>			
<b>BY:</b> (Full name of person providing First Aid)			
<b>HAS EMPLOYEE RETURNED TO WORK?</b>			
<input type="checkbox"/> No, still off work		<input type="checkbox"/> Yes, Date Returned ____/____/____	
		<input type="checkbox"/> Restricted Work	<input type="checkbox"/> Regular Work
<b>Policy :- Please tick the relevant policy this injury relates to</b>			
Liverpool <input type="checkbox"/>	Maitland <input type="checkbox"/>	Newcastle <input type="checkbox"/>	Parramatta <input type="checkbox"/>
Choice HR <input type="checkbox"/>	Penrith <input type="checkbox"/>	Logistics <input type="checkbox"/>	Challenge <input type="checkbox"/>
<b>Consultant/Account Manager: (Print Name)</b>		<b>Employee:</b>	
Print Name: _____		Print Name: _____	
Signature: _____ Date ____/____/____ day month year		Signature: _____ Date ____/____/____ day month year	

**The Manager of the injured person shall investigate the accident and complete all items below.**

**Accident Cause**

**A.** Check one or more causes that contributed to accident

- |  |   |
|--|---|
| 1 Design of Plant Facilities, or Equipment                   | 10 Incorrect or Lack of Personal Protective Equipment |
| 2 Job Planning or Instruction Inadequate                     | 11 Inadequate Knowledge or Skill                      |
| 3 Rules, Procedures or Work Method Not Followed              | 12 Chemical Exposure, Personal Hygiene                |
| 4 Rules, Procedures or Work Method Inadequate                | 13 Improper Vehicle Operation                         |
| 5 Incorrect Body Position in Relation to Work                | 14 Environmental Factors, Weather                     |
| 6 Guarding or Protective Devices Not Provided or Ineffective | 15 Inattention to Details of Job                      |
| 7 Plant Equipment Operated Incorrectly                       | 16 Action of Fellow Employee                          |
| 8 Housekeeping Congested, Incorrect Storage                  | 17 Maintenance, Inspection Not Adequate               |
| 9 Incorrect Tools or Mechanical Aids Used                    | 18 Other  |

**B.** Indicate Primary Accident Cause (enter appropriate No.) \_\_\_\_\_ and explain reason for selection.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Corrective Action**

**C.** Check one or more actions that will prevent a recurrence.

- |  |   |
|--|---|
| a Provide More Complete Job Instruction                      | f Provide Proper or Additional Tools, Equipment |
| b Review Job Planning, Regulate Job Pace                     | g Reinforce Employee Training                   |
| c Develop or Revise Work Method                              | h Modify Plant or Equipment                     |
| d Enforce Work Rules, Revise Standards                       | i Contact Third Party to Effect Correction      |
| e Provide Proper or Additional Personal Protective Equipment | j Other   |

**D.** Indicate Primary Corrective Action (enter appropriate letter) \_\_\_\_\_ and explain reason for selection.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Follow-Up Action**

**E.** What Follow-Up is Required?

**F.** Completion Date for Corrective Action (d/m/y) \_\_\_\_/\_\_\_\_/\_\_\_\_ Responsibility of:

<p><b>Investigating Team: (Print Name)</b></p> <p>1. _____ 2. _____</p> <p>3. _____ 4. _____</p>	<p><b>Employee</b></p> <p><b>Print Name:</b> _____</p> <p><b>Signature:</b> _____ <b>Date</b> ____/____/____ day month year</p>
<p><b>Reviewed By:</b></p> <p><b>Consultant</b> _____ <b>Date</b> ____/____/____ day month year</p> <p><b>Manager</b> _____ <b>Date</b> ____/____/____ day month year</p>	<p><b>Final Review By:</b></p> <p><b>National OHS Manager or National Risk Assurance Manager</b></p> <p>_____ <b>Date</b> ____/____/____ National OHS Manager / National Risk Assurance Manager day month year</p>

