Incident Report Form

Workplace Incident Documentation

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Report Promptly

All workplace incidents must be reported immediately or as soon as practicable. Serious incidents may require notification to SafeWork or your state WHS regulator. If anyone is injured, ensure first aid is provided and call emergency services (000) if needed.

Section 1: Reporter Details

Full Name *

Employee ID

Position / Job Title *

Department / Team *

Contact Phone *

Date and Time of Report *

Your involvement in the incident:

- [ ] I was directly involved / injured
- [ ] I witnessed the incident
- [ ] I was told about the incident by someone else
- [ ] I discovered the incident / hazard

Section 2: Incident Details

Date of Incident *

Time of Incident *

Exact Location (building, floor, room, area) *

Work Site / Address *

Section 3: Type of Incident

What type of incident occurred? (Select all that apply)

- [ ] Injury to worker
- [ ] Injury to visitor / contractor / member of public
- [ ] Near miss (no injury but potential for harm)
- [ ] Property damage
- [ ] Vehicle incident
- [ ] Slip, trip or fall
- [ ] Manual handling injury
- [ ] Struck by / against object
- [ ] Caught in / between
- [ ] Cut / laceration
- [ ] Chemical exposure
- [ ] Electrical incident
- [ ] Fire / explosion
- [ ] Environmental incident
- [ ] Security incident / threat
- [ ] Aggressive behaviour / assault
- [ ] Other (please specify below)

If other, please specify:

Section 4: Description of Incident

Describe what happened in detail (who, what, when, where, how): *

Events Leading to Incident

What was happening immediately before the incident?

Contributing Factors

What factors may have contributed to this incident?

Section 5: People Involved / Injured

Injured Person 1

Name

Employee / Visitor / Contractor

Position / Company

Contact Details

Nature of Injury

Body Part(s) Affected

Injured Person 2 (if applicable)

Name and Details

Nature of Injury

Section 6: Witnesses

Witness 1 - Name, Position, Contact

Witness 2 - Name, Position, Contact

Witness 3 - Name, Position, Contact

Section 7: Immediate Actions Taken

What immediate actions were taken? (Select all that apply)

- [ ] First aid administered
- [ ] Ambulance called (000)
- [ ] Person taken to hospital
- [ ] Person sent to GP / medical centre
- [ ] Area secured / cordoned off
- [ ] Equipment isolated
- [ ] Manager / supervisor notified
- [ ] Photos / evidence collected
- [ ] Hazard removed / made safe
- [ ] Work stopped in affected area
- [ ] No immediate action required

First aider name (if applicable)

Details of immediate actions taken:

Section 8: Medical Treatment

What medical treatment was required / provided?

- [ ] None required
- [ ] First aid only
- [ ] Medical attention - GP
- [ ] Medical attention - Hospital outpatient
- [ ] Hospital admission
- [ ] Ongoing treatment required

Medical facility name (if applicable)

Treating doctor name (if known)

Section 9: Severity Assessment

Actual outcome:

- [ ] No injury
- [ ] Minor injury - first aid only
- [ ] Medical treatment required
- [ ] Lost time injury (time off work)
- [ ] Serious injury
- [ ] Fatality
- [ ] Property damage only

Potential outcome (if circumstances were different):

- [ ] Could have resulted in serious injury
- [ ] Could have resulted in fatality
- [ ] Could have resulted in multiple injuries

Section 10: Regulatory Notification

Does this incident require notification to SafeWork / WHS regulator?

- [ ] Yes - notifiable incident (death, serious injury, dangerous incident)
- [ ] No - not a notifiable incident
- [ ] Unsure - needs assessment

If notified, reference number

Date and time of notification

Section 11: Declaration

- I declare that the information provided in this report is true and accurate to the best of my knowledge.
- I understand that all workplace incidents must be reported regardless of severity.
- I agree to cooperate with any investigation into this incident.

Reporter Signature

Signature: _____ Date: _____

Section 12: Manager / Supervisor Review

Manager Name

Date Reviewed

- [ ] Incident details verified
- [ ] Investigation required
- [ ] Corrective actions identified
- [ ] WHS committee notified
- [ ] Workers compensation claim lodged

Initial corrective actions / recommendations:

Manager Signature

Signature: _____ Date: _____

Section 13: For Office Use Only

Incident Reference Number

Investigation Assigned To

Date Investigation Completed

Root Cause Identified

Corrective actions implemented:

Date Closed

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