



Accident Report Form

<http://www.safetygroup.com.au>

Surname / Family Name

First Name

Day and Date of incident
Day Date

Time of incident Time Shift Commenced

Usual employment location

Location of incident
Site name or Unique reference number

Exact Location of accident
Example - Near main entrance, Storeroom, in car park, Behind workshop, etc.

What was the injury or incident
Give Full Details - eg: Cut on little finger on left hand, slip on wet floor, etc

How did the incident happen? What were you doing when the incident occurred?
(Describe in detail what caused the incident. Attach additional information if necessary)
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What protective equipment was being used or worn a the time of the accident?
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.....

Describe any medical treatment or follow up action required after the Incident?
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.....

Was anyone else involved in the incident? If yes, please provide details.
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.....

Consequence Of Incident

Injury

- Fatality
- Lost Time
(Not available for normal work the day after an injury)
- Medical Treatment
- First Aid
- No Injury

Person Affected

- Customer
- Employee
- Contractor

Property Damage (Estimation only required)

- Building: \$.....
- Tools: \$.....
- Plant: \$.....
- Other: \$.....

Witness's names and contact number (attach witness statements if available)

Name	Contact Details

To whom was the accident reported?

When was the accident reported?

In your opinion, what action if any, could be taken to prevent a recurrence of the incident ?

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Was an ambulance called ? No Yes→ Incident No:

Where the police called ? No Yes→ Incident No:

Was Trauma Counselling Offered ? No Yes→ Date Contacted:

Was Medical treatment Sought ? No Yes→ Location:

Date & Time

.....
Employee Name

.....
Signature

.....
Date

SUPERVISORS USE ONLY

To whom was the accident reported?

Date and time accident reported?

Supervisors Comments & Initial Investigation Notes:

.....

Supervisors Follow Up Action Required:

.....

Target date for follow up action:

Follow up action to be performed by whom?:

Will the injured employee be off work for more than 7 calendar days? Yes No

Have all possible actions been taken to prevent a re-occurrence? Yes No

.....
Supervisors Signature & Name

.....
Date Signed

Important Notes: Requirements for reporting incidents vary between states. You should be aware that you may be required to report this incident to your Workers Compensation insurer within 48 hours. In addition you may be required to report this incident to the Workcover Authority. You must keep this incident report for the period of time specified by the Workcover authority in your state. Please visit our website for links to the Workcover Authority in your state.