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Workcover incident report form qld

Incident / Accident Report

OFFICE USE ONLY	Followed work instructions? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cause of accident? <input type="checkbox"/> Safety <input type="checkbox"/> Health	Reported? <input type="checkbox"/> Yes <input type="checkbox"/> No
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When an incident, accident or other event with the potential to cause serious injury, illness or an adverse environmental impact (EIA) is reported, the first priority is to ensure the safety of all persons involved. The Principal Contractor is to be advised IMMEDIATELY. An incident will be marked following discussion with the Principal Contractor, as to who will carry out the accident / incident investigation.

A copy of the completed form is to be sent to Principal Contractor

Client: _____	Project: _____
Site Address: _____	
Has the client been notified? Yes [] No []	
Time of accident/incident: _____	Date of accident/incident: ____/____/____
Accident / incident witnessed by (if applicable): _____	
Name of injured person's and age (if applicable): _____	
Location of accident / incident (be specific): _____	
Nature of injury / illness / incident: _____	
Occupation of the injured person's (if applicable): _____	
PCBU: _____	
Refused / transferred to: _____	
Damage to equipment / property: Yes [] No []	
Description of accident / incident (Attach additional pages if required) (Describe in detail, including names of witnesses, photos etc.)	
Recommended preventive action: _____	
Have the relevant authorities (WorkCover, EPA, Police) been notified? Yes [] No []	
Completed by: _____	Position: _____
Date: ____/____/____	

Replace this page with the name of your company? 1 of 1 [View Data Entry Positioning](#)

INFORMATION ABOUT PERSON INVOLVED IN THE INCIDENT			
Full Name: _____			
Home Address: _____			
<input type="checkbox"/> Student	<input type="checkbox"/> Employee	<input type="checkbox"/> Visitor	<input type="checkbox"/> Vendor
Phone Numbers: Home: _____	Cell: _____	Work: _____	
INFORMATION ABOUT THE INCIDENT			
Date of Incident: _____	Time: _____	Police Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Location of incident: _____			
Description of incident (what happened, how it happened, factors leading to the event, etc.) Be as specific as possible (attach additional sheets if necessary)			
Were there any witnesses to the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach separate sheet with names, addresses, and phone numbers			
Was the individual injured? If so, describe the injury (laceration, sprain, etc.), the part of body injured, and any other information known about the resulting injury(ies)			
Was medical treatment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused If yes, where was treatment provided: <input type="checkbox"/> on site <input type="checkbox"/> Urgent Care <input type="checkbox"/> Emergency Room <input type="checkbox"/> Other			
REPORTER INFORMATION			
Individual Submitting Report (print name): _____			
Signature: _____			
Date Report Completed: _____			
FOR OFFICE USE ONLY			

Record No: _____

ACCIDENT/INCIDENT REPORT FORM

Personal details

Name: _____

Occupation: _____

Section/Dept: _____ Date of report: ____/____/____

Accident/incident details

Date: _____ Time: _____ Date reported: ____/____/____

Location: _____ Witness: _____

Reported to whom: _____

Full accident/incident details – what happened, or in the case of a near miss, what could have happened

Injury – Nature of Injury

<input type="checkbox"/> Contusion/crush	<input type="checkbox"/> Burn	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Amputation
<input type="checkbox"/> Laceration/open wound	<input type="checkbox"/> Superficial injury	<input type="checkbox"/> Foreign body	<input type="checkbox"/> Internal injury
<input type="checkbox"/> Concussion	<input type="checkbox"/> Sprain/strain	<input type="checkbox"/> Fracture	<input type="checkbox"/> Dermatitis

Location of Injury

<input type="checkbox"/> Head/face	<input type="checkbox"/> Eye	<input type="checkbox"/> Internal organs
<input type="checkbox"/> Hand/fingers	<input type="checkbox"/> Shoulder/arms	<input type="checkbox"/> Trunk (other than back)
<input type="checkbox"/> Hip/leg	<input type="checkbox"/> Foot/toes	<input type="checkbox"/> Back
<input type="checkbox"/> Other (state) _____		

Results of accident

Lost time injury Y / N No. of days: _____ days Workers' compensation Y / N

Treatment received: First aid Doctor Hospital

Damage to equipment/buildings/vehicles etc.

What was damaged? _____

Extent of damage: _____

Contributing factors

What were the contributing factors (if any)? _____

Corrective actions

Immediate actions _____

What controls can be put in place to prevent this from happening again? _____

