

Please print clearly and tick the correct box**Status:** Employee Patient Other**Outcome:** Near miss Injury**1. DETAILS OF INJURED PERSON**

Name: _____ Phone: (H) _____ (W) _____

Address: _____ Sex: M F

_____ Date of birth: _____

Days and times at the service: _____ Length of attendance: _____

2. DETAILS OF INCIDENT

Date: _____ Time: _____

Location: _____

Describe what happened and how: _____

_____**3. DETAILS OF WITNESSES**

Name: _____ Phone: (H) _____ (W) _____

Address: _____

4. DETAILS OF INJURY

Nature of injury (eg sprain) _____

Cause of injury (eg fall) _____

Location on body (eg back, left forearm) _____

First Aid given Yes No

First Aider name: _____

Treatment: _____

Referred to: _____

SECTION 6-9 MUST BE COMPLETED BY MANAGER

6. DID THE INJURED PERSON STOP EXERCISING?

Yes No If yes, state date: _____ Time: _____

Outcome:

- Treated by doctor Hospitalised Workers compensation claim
 Returned to normal work Alternative duties Rehabilitation

7. INCIDENT INVESTIGATION (comments to include causal factors):

8. RISK ASSESSMENT

Likelihood of recurrence: _____

Severity of outcome: _____

Level of risk: _____

9. ACTIONS TO PREVENT RECURRENCE

Action	By whom	By when	Date completed

10. ACTIONS COMPLETED

Signed (Manager): _____ Title: _____

Date: _____

Feedback to person involved

Date: _____

11. REVIEW COMMENTS

Personal/ Staff meeting: _____

Reviewed by site Manager (signed): _____ Date: _____

Reviewed by Health & Safety Rep.(signed): _____ Date: _____