

Incident Report

Contract Details			
Accredited contractor			
Accreditation number			
Project name			
Client			
Contact person		Position	
Telephone		Email	
Who is the employer of the injured person			
Incident Details			
Date of incident:	Time of incident:	Date form completed:	
Please circle incident type : Fatality Serious Injury Dangerous Occurrence Incapacity			
Please tick the incident sub-category:			
<input type="checkbox"/> Falls, trips and slips of a person (Group 0) <input type="checkbox"/> Being hit by moving objects (Group 2) <input type="checkbox"/> Body stressing (Group 4) <input type="checkbox"/> Chemical and other substances (Group 6) <input type="checkbox"/> Mental stress (Group 8)		<input type="checkbox"/> Hitting objects with part of the body (Group 1) <input type="checkbox"/> Sound and pressure (Group 3) <input type="checkbox"/> Heat, electricity and other environmental factors (Group 5) <input type="checkbox"/> Biological factors (Group 7) <input type="checkbox"/> Vehicle incidents and other (Group 9)	
Project site location/address where incident occurred:			
Description of injury: If applicable, indicate part of body that was injured and extent of injury			
How did the incident occur? – please list precise details including contributing factors			
Have you conducted any incident investigation regarding this incident?			
<input type="checkbox"/> Yes - please provide information regarding the investigation, such as a copy of the incident investigation report and details of actions that has been subsequently taken to reduce the risk of a similar future occurrence			
<input type="checkbox"/> No - please provide information regarding actions that has been subsequently taken to reduce the risk of a similar future occurrence.			

Additional Comments:

Name:

Signature:

Position:

Date: