**Form 4: Incident and Accident Reporting Form/Register**

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| **Record of Accident/Incident/Serious Harm** | |
| *To be completed by the Manager and injured person and sent to the Health and Safety Representative or CEO within 48 hours of the event occurring* | |
| Is it an ❑ Accident ❑ Incident/Near Miss ❑ Condition, e.g. OOS | |
| Surname: ……………………………………………………....  First name(s): ……………………………………………….....  Residential address: ……………………………………….….  ……………………………………………………………………  ……………………………………………………………………  Telephone: …………….………………………  Gender: ❑ M ❑ F  Date of event: ………………………Time: ………… am/pm  Date reported:……………………………………………………..  If OOS - date of visit to Doctor: …………………………………  Hours worked since arrival at work (if applicable)…………….  Shift: ❑ Day ❑ Evening ❑ Night  Location where event occurred: ………………………………  …………………………………………………………………….  Occupation/position of injured person: ……………………….  …………………………………………………………………….  Type of employment (if applicable):  ❑ Full-time ❑ Part-time ❑ Non-employee ❑ Student  **Period of employment/student**  ❑ 1st week ❑ 1st month  ❑ 1-6 months ❑ 7 months - 1 year ❑ 1-5 years ❑ Over 5 years  **Nature of injury:**  ❑ No injury ❑ Mental disorder ❑ Superficial ❑ Damage artificial aid  ❑ Open wound ❑ Poisoning/toxic effect  ❑ Sprain or strain ❑ Occupational hearing loss  ❑ Fracture, spine ❑ Amputation, including eye loss  ❑ Bruising/crushing  ❑ Other fractures  ❑ Dislocation  ❑ Head injury  ❑ Multiple injuries  ❑ Puncture wound  ❑ Burns  ❑ Chemical reaction  ❑ Nerves/spinal cord  ❑ Internal injury, trunk  ❑ Foreign body  ❑ Seizure  ❑ Fatal | **Nature of disease:**  ❑ Disease skin  ❑ Disease nervous system  ❑ Disease digestive system  ❑ Disease respiratory system  ❑ Disease circulatory system  ❑ Disease infectious or parasitic  ❑ Disease musculo-skeletal system  ❑ Tumour (malignant or benign)  **Injured part of body:**  ❑ Neck  ❑ Trunk  ❑ Head  ❑ Internal organs ❑ Upper limb(s)  ❑ Lower limb(s) ❑ Multiple locations  **Mechanism of event:**  ❑ Fall, trip, or slip  ❑ Sound or pressure ❑ Biological factors  ❑ Allergic Reaction ❑ Body stressing ❑ Mental stress  ❑ Being hit by moving objects ❑ Heat, radiation, or energy ❑ Chemicals or other substances ❑ Hitting objects with part of the body  **Was a ‘Significant Hazard’ involved?**  ❑ Yes ❑ No  **Type of treatment given:**  ❑ Nil ❑ First aid  ❑ Doctor ❑ Hospital  **Agency of injury:**  ❑ Machinery or (mainly) fixed plant ❑ Mobile plant or transport ❑ Tools, appliances, equipment (powered) ❑ Tools, appliances, and equipment  (non-powered) ❑ Chemical or chemical products ❑ Material or substance  ❑ Environmental agency ❑ Animal human or biological agency  (not bacterial/virus ❑ Bacterial or virus  ❑ Sport |

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| THE INVESTIGATION: Describe what happened.  ANALYSIS: What caused the event?  PREVENTION: What action has or will be taken to prevent a recurrence?  By whom?……………………………………….……… By when? …………………………………………..  Were ACC forms completed? ❑ Yes ❑ No  Has time been lost from work? ❑ Yes ❑ No  If yes, how many days? ………………………..…………  Manager: (Name)………….………….………….………….………….………….………….…………  Signature: …………….…………………….………… Date: …………….…………………….…………  **Consent** (in the case of an ACC claim)  I authorise the CEO or Health and Safety Representative to obtain medical and any other records that are, or may be, relevant to this claim.  I authorise disclosure to any accident insurer of personal information and health information held by other parties relating to the claim.  I authorise disclosure of my health and other information relating to this claim to: my employer, ACC, contracted health or rehabilitation providers, and employee representatives.  Injured Person: (Name)………….………….………….………….………….………….………….…………  Signature: …………….…………………….………… Date: …………….…………………….…………… |