**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/pmDate reported:……………………………………………………..If OOS - date of visit to Doctor: …………………………………Hours worked since arrival at work (if applicable)…………….Shift: ❑ Day ❑ Evening ❑ NightLocation 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 ❑ NoHas 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: …………….…………………….…………… |