

# BETHANIA LUTHERAN PRIMARY SCHOOL

## INCIDENT REPORT / RECORD

### ADULT

#### PART A

<b>Details of Injured Person</b>					
Given names .....	Surname .....				
Date of Birth .....	<input type="checkbox"/> Male	<input type="checkbox"/> Female			
Residential Address .....					
Telephone:	Work .....	Home .....			
<input type="checkbox"/> Employee	<input type="checkbox"/> Contractor	<input type="checkbox"/> Member of Public			
Contractor's / Employer's Name and Address: .....					
.....					
<b>Nature of Injury or Work Caused Illness, e.g. fracture, sprain and strain, burns, etc.</b>					
.....					
<b>Type of Incident:</b>					
<input type="checkbox"/> injury	<input type="checkbox"/> serious bodily injury	<input type="checkbox"/> worked caused illness	<input type="checkbox"/> dangerous event		
Notify WHSQ	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was injury / illness fatal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Detail of Incident:</b>					
Date .....		Time .....			
Where did the event happen? .....					
Describe how the incident happened (what started the sequence of events, the sequence of events, the final thing that happened). Attach page if necessary.					
.....					
.....					
.....					
.....					
<b>Signature of person completing Part A:</b>					
Name: .....		Signature: .....		Date: .....	
<b>Employer notified?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					

## PART B – ADULT INCIDENT REPORT / RECORD

<p><b>Workers involved were:</b></p> <p>Qualified to undertake the work    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Adequately supervised                    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Provided with documented Work procedures                            <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Other: .....</p> <p>.....</p> <p>.....</p>	<p><b>Work environment was:</b></p> <p>Clean    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Adequately lit                                <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Well ventilated                                <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>A confined area                                <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Uncluttered                                    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Other: .....</p> <p>.....</p>
<p><b>Name of Witness to Accident / Incident</b></p> <p>..... Phone ..... Statement taken?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>..... Phone ..... Statement taken?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>Notified Safety Officer?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	
<p><b>Have you received any claim from, or on behalf of, the injured Third Party either verbally or other means?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>If yes, please give details (attach more information)</p>	
<p><b>Was a motor vehicle involved?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Details / Description of damage .....</p> <p>.....</p>	
<p><b>Outcome of injured person</b></p> <p>Returned to work at ..... am / pm on ..... (date).    <b>Has not returned to work</b> <input type="checkbox"/></p>	
<p><b>Action taken to prevent occurrence:</b></p> <p>1. ....</p> <p>2. ....</p> <p>3. ....</p> <p>4. ....</p> <p>5. ....</p>	
<p><b>Action completed:</b>    <b>Signature:</b> .....    <b>Date:</b> .....</p> <p>.....</p>	
<p>.....</p> <p><b>Safety Officer</b></p>	<p>.....</p> <p><b>Commercial Manger</b></p>
<p>.....</p> <p><b>Principal</b></p>	

