Work Health and Safety Incident Report

This form is to be submitted to your direct line manager/ priest within 24 hours.
If this is a notifiable incident, contact your direct line manager immediately
& call your WHS Unit on 0499 300 139.

A 'notifiable incident' as outlined in the WHS Act is the death of a person, a serious injury or illness or a dangerous incident arising out of the conduct of a business or undertaking at a workplace. 'Notifiable incidents' may relate to any person – whether an employee, contractor or member of the public.

Occurrence Type: *(You may need to complete more than 1 section of this form. Tick and complete as applicable)*

☐ Incident/Injury/Illness ☐ Near Miss (no injury) ☐ Hazard ☐ Equipment/Property Damage

Archdiocesan Organisation:			
☐ **Parish**: ☐ **Directorate:**		**Location/Address:**	
Person directly impacted:			
Given Name:		**Last Name:**	
Location:		**Contact number:**	

Person / Staff Type:

☐ Client	☐ Employee – Full Time	☐ Prac Student
☐ Visitor	☐ Employee – Part Time	☐ Work Experience
☐ Contractor	☐ Employee – Casual	☐ Volunteer
☐ Member of public	☐ Parishioner	☐ Other: _____

SECTION 1 - Details of Occurrence:

Date of Occurrence:	**Time:**	:	☐AM ☐PM
Date Reported:	**Time Reported:**	:	☐AM ☐PM

Location of Occurrence: *(may be different to work location)*	
Detailed Description:	
Other factors: *(E.g. equipment, wet floor, weather, car/driver etc.)*	
Immediate Action: (*Taken, Time and Date)*	

Any other person / witness involved? ☐ Yes ☐ No	Name: Contact #:	☐ Employee: ☐ Other: _____
Any other person / witness involved? ☐ Yes ☐ No	Name: Contact #:	☐ Employee: ☐ Other: _____

Other reports/ forms required:

☐ N/A ☐ Motor Vehicle Claim ☐ WorkCover Claim

SECTION 2 – Injury Details:

Injury / Illness: ☐ Yes ☐ No ***If No, skip 'SECTION 2 and complete 'SECTION 3 – Reporting'***

Was the person injured a staff member?	☐ Yes - ***if yes, complete the below questions*** ☐ No - *if no, go to 'Treatment'*
On the day of the incident, what time did you:	Start Work: : ☐AM ☐PM Finish Work: : ☐AM ☐PM
Did you have to leave the shift / workplace? *If yes, what time did you leave?*	☐Yes ☐ No : ☐AM ☐PM
Time Lost: ☐Yes ☐ No	**Total hours / Days:**

Treatment:

☐ No Treatment	☐ Medical Treatment (e.g. attend doctor)
☐ First Aid Details: Who administered: ☐ Ambulance Required	☐ Hospital Treatment Name of Hospital: ☐ In- Patient ☐ Emergency Only

Other Information:

Symptoms and name of illness *(if known):* ☐ N/A

Time of Onset: Did person arrive with symptoms: ☐ Yes ☐ No ☐ N/A

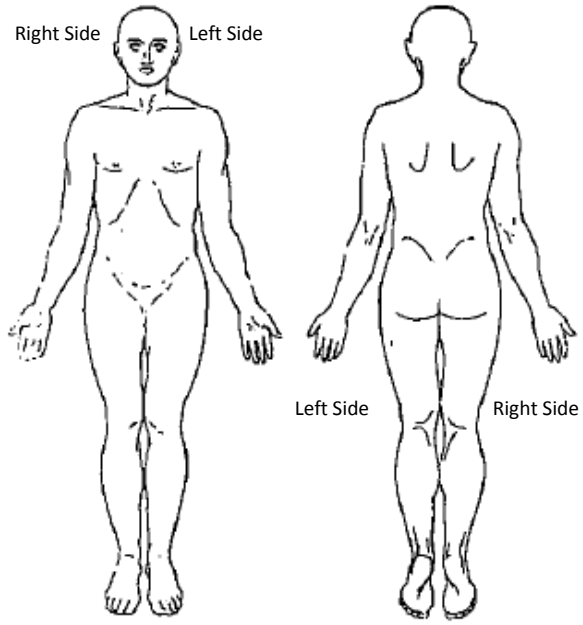
Has anyone else displayed similar symptoms in the last week: ☐ Yes ☐ No ☐ N/A

Is it a communicable / contagious illness: ☐ Yes ☐ No ☐ N/A

Prior instances or impacting medical conditions & treatment information: ☐ N/A

Location of suspected injury:

Identify the location of the injury by circling on the diagram below and **tick** as applicable



- ☐ Allergic Reaction
- ☐ Amputation
- ☐ Asphyxiation
- ☐ Asthma
- ☐ Bite - Animal
- ☐ Bite - Human
- ☐ Blood nose
- ☐ Bruise/Crush
- ☐ Bump/Knock
- ☐ Burn
- ☐ Concussion
- ☐ Dental Injury
- ☐ Dislocation
- ☐ Ear injury
- ☐ Eye injury
- ☐ Fainting
- ☐ Foreign Body
- ☐ Fractures/Broken Bones
- ☐ Graze/Scratch
- ☐ Headaches
- ☐ Hernia
- ☐ Inflammation
- ☐ Internal Injury
- ☐ Joint Damage
- ☐ Laceration/Cut/Abrasion
- ☐ Nausea
- ☐ Psychological/Stress
- ☐ Rash/Dermatitis
- ☐ Smoke inhalations
- ☐ Sprain or strain (inc. Muscular/body Stressing)
- ☐ Tendons/Carpel/Tunnel Syndrome
- ☐ Vision Impairment
- ☐ Vomit/Illness
- ☐ Weather effects
- ☐ Whiplash
- ☐ Other: _____

SECTION 3 - Reporting:

Verbally reported to:	Date Time ☐AM ☐PM
Verbally reported by:	Position:
Name of person completing report:	Position: Contact Number:

☐ I acknowledge this is a true representation of the incident / event

Signature: Date:

Report completed on behalf of (if applicable):

Once this report is completed, attach to the Manager Incident Form and email to your WHS Unit

Work Health and Safety Incident Report Action Sheet

Manager Use Only

A timeframe of 24 hours applies for Critical and Notifiable Incidents.

A 'notifiable incident' as outlined in the WHS Act is the death of a person, a serious injury or illness or a dangerous incident arising out of the conduct of a business or undertaking at a workplace. 'Notifiable incidents' may relate to any person – whether an employee, contractor or member of the public. If you believe the incident is 'notifiable' call your WHS Unit immediately!!

ATTACH TO THE INCIDENT REPORT FORM PART ONE AND ONCE COMPLETE EMAIL TO YOUR WHS UNIT

Other Forms Received:

☐ Incident Form Part 1 (Required) ☐ Motor Vehicle Claim ☐ WorkCover Claim

Action Taken: *(Tick as applicable)*

☐ Phone contact with Injured Person, Decision Maker/ Next of Kin or Support Staff:	By Who:	
	Date:	
☐ Personal contact with Injured Person, Decision Maker/ Next of Kin or Support Staff:	By Who:	
	Date:	
☐ Action implemented: *List actions in Preventative Action Required Section (Next Page)*	By Who:	
	Date:	

☐ Has this incident been identified as a notifiable incident:

(WHS UNIT TO NOTIFY ONLY – CALL WHS UNIT IMMEDIATLY – (Outside hours number: 0499 300 139)

☐ Incident Investigation requested?	By Who:	
	Date:	

Reported To: *(Tick as applicable)*

☐ Manager:	By Who:	
	When:	
☐ WHS unit: Note: Contact WHS Unit	By Who:	
	When:	
☐ WorkCover Claim Lodged: Note: Contact Return to Work Coordinator	Date Logged:	
	Claim Ref: *(if known)*	#

What is the workers capacity for work? - ☐ N/A (select if not employee)

☐ Returned to pre-injury duties	☐ Restricted work injury *(suitable Duties)*	☐ Lost time injury *(not able to work)*

Cause: *(Tick as applicable)*

☐ Absconding	☐ manual handling
☐ Assault by: ☐ Staff ☐ Client ☐ Other: _____	☐ medical condition
☐ Assault of: ☐ Staff ☐ Client ☐ Other: _____	☐ Operating equipment
☐ Bites and Stings	☐ Child safety event
☐ Bullying and Harassment	☐ Self-harm
☐ Sexual harassment	☐ Slips, trips and Falls (including falls from heights)
☐ Children playground incident	☐ Damage, Theft or Loss of Property or Equipment
☐ Contact with animal	☐ Thermal (Hot/Cold), Radiation or Electrical Exposure
☐ Exposure to chemical / and other substance	☐ Vehicular Accident
☐ Hit by moving object	☐ Wheelchair Accident
☐ Infection/ control/ hygiene (e.g. Biological substance)	☐ Other: _____

Preventative Action Required: *(Tick as applicable)*		
Attach all additional notes and initial incident form and to this Manager Incident Form and email to your WHS Unit	☐ Change Work Environment	☐ Performance Management
	☐ Additional Training Required	☐ Equipment / Resources Required
	☐ Change Work Procedure	☐ Modify Equipment

Date	**Action Taken**	**Outcomes**

Comments:

Manager Name:		Signature:	
Date:			

Once this report is completed, attach Section One of the incident form and all relevant paperwork and email to your WHS Unit for uploading into the incident register.

Work Health & Safety Unit Use Only:			
Entered into register by:		Received Date:	/ /20
Reference #:		Date entered into incident register:	/ /20
☐ Incident Investigation required?		By Who:	
		Date:	/ /20
☐ Incident investigation completed:		By Who:	
		Date:	/ /20
☐ Is this incident notifiable? **(WHS Unit to notify only)**		☐ Yes ☐ No	
		By Who:	
		Date:	/ /20
WHSQ Notices:	☐ Improvement Notice ☐ Prohibition Notice	☐ Infringement Notice ☐ Non Disturbance Notice	
Comments:			

For parishes please email to whs@bne.catholic.net.au.