INCIDENT/INVESTIGATION REPORT

Completed at Initial Visit

Administration details (to be completed in consultation with the person involved in the incident)

Name of Person:	**Payroll no:**	**Report received by:**
Maxima Placement: YES NO	**Fee For Service: YES NO**	
Occupation:		**Name of Maxima Personnel:**
Phone no:		**Name of Host Employer:**
Date reported to Maxima:	**Time of report :**	**Address:**
Incident reported by:		**Supervisor Name:**
Date of incident:	**Time of incident:**	**Mobile:**

DETAILS of INCIDENT

Where did the incident occur (address& location)? e.g.: indoors / outdoors
What was the activity at the time of accident? e.g.: walking across yard
What happened? e.g.: slipped on concrete
What factors, if any, contributed to the incident? e.g.: water on concrete, carrying heavy load

WITNESSES:

NAME	HOME & MOBILE NUMBER

TREATMENT of INJURY (please circle appropriate one)

01. None	03. First Aid (Time lost)	05. Treatment at a hospital	07. Surgery required
02. First Aid (Return to work)	04. Medical/Dental (treatment)	06. Admitted to hospital	08. Fatal

NATURE of SEVEREST INJURY: (please circle appropriate one)

01. Fracture	06. Crushing	11. Bite/ Sting	16. Head injury
02. Dislocation	07. Amputation	12. Psychological injury	17. Other (specify)
03. Strain/Sprain	08. Bruising	13. Shock	_____
04. Laceration/Cut	09. Dental Injury	14. Concussion	_____
05. Burn/Scald	10. Overuse/RSI	15. Eye Injury	

PART of BODY MOST SEVERELY INJURED: (please circle appropriate one)
Right side OR Left side

01. Head	08. Back	15. Genitals	22. Other (specify) _____
02. Throat	09. Collarbone (Shoulder)	16. Buttocks	_____
03. Teeth	10. Trunk (Chest)	17. Leg (Hip, Thigh, Knee, Ankle)	_____
04. Ears	11. Abdomen	18. Foot (Toes)	
05. Nose	12. Arm (Wrist, Elbow, Forearm)	19. Psychological system	
06. Eyes	13. Hand (Fingers, Thumb)	20. Voice	
07. Neck	14. Pelvis	21. Multiple locations	

CAUSE of INCIDENT: (please circle appropriate one)

01. Hit/ Injured by another person	09. Power tool	17. Thermal exposure
02. Hit/ Injured by object	10. Insect/Animal	18. Overuse
03. Hit object	11. Explosion exposure	19. Physical harassment or assault
04. Lifting/moving object	12. Electric shock	20. Verbal harassment or assault
05. Lifting/moving person	13. Fire	21. Work pressures
06. Reaching/Stretching/Bending	14. Collapse of structure	22. Psychological other, said to arise from work
07. Slip and fall	15. Exposure to noise	23. Other (specify _____
08. Hand tool	16. Exposure to chemical/substances	

WILL this INCIDENT result in a WORKERS COMPENSATION CLAIM? (Please circle appropriate one)

01. Yes (Workers Compensation forms required)
02. No (All costs will be the responsibility of the injured worker, and lost time can be claimed against sick leave.)
However this will not prevent you from lodging a claim for this injury at a later date.

I……..……..…..(person's name), have been consulted and advised of my options in respect to the above incident.

Signed…….. Date ……../……..… /……..

INVESTIGATION DETAILS

The aim of the investigation is to identify why the system has failed, RCA (Root Cause Analysis)not to apportion blame.

Provide a brief description of the principal hazard(s) involved in the incident: e.g.: Dust, Lighting, Electrical, Inadequate training: Tool design, Equipment design, Job/task design, Work station design, Manual handling.
Had a formal risk assessment of the job or task been carried out? ☐ **Yes** ☐ **No** **Risk Assessment file name:**
Provide a brief explanation of why a formal risk assessment had not been carried out?
If a formal risk assessment had been carried out: Did it identify the hazard(s) involved in the incident? ☐ **Yes** ☐ **No** **Were risk controls in place to prevent injury/illness arising from the hazard(s)?** ☐ **Yes** ☐ **No** ***If yes, provide a brief description of any risk controls in place to prevent injury/illness arising from the hazards.***
Please describe why the control did not prevent the injury: • Poor design and did not prevent exposure to the hazard or did not work properly • Risk controls were not appropriately applied • Employee did not use or apply risk control
If no, provide a brief description of the reasons why the risk controls were not in place.

HAZARD CONTROL MEASURES

Controls	Action	Time Frame	Responsibility
Eliminated e.g. remove noisy equipment, purchase pre-cut items.			
Substitution e.g. lift smaller packages, use a less toxic chemical. Electrical forklift in place of petrol-driven. Vacuum rather than sweep.			
Isolate e.g. place barriers around a spill until cleaned up, locate photocopier in separate, well-ventilated room.			
Engineering e.g. provide a trolley to move heavy loads, place guards on moving parts of machinery.			
Administrative e.g. introduce job rotation, shorter task shifts, ensure equipment is maintained regularly, safe work practices, instruction and training.			
Personal Protective Equipment e.g. provide hearing and eye protection, hard hats, gloves, masks.			

Maxima Representative

_____ _____ _____

Name **Signature** **Date**

Client Representative

_____ _____ _____

Name **Signature** **Date**

Hazard Control Measures Follow up (office use only)

Has Risk Assessment been reviewed to reflect new Controls **Y** **N**

Any further actions required **Y** **N**

Comments

_____

Notifiable Incident
Does the incident need to reported to relevant State Authority- YES NO (Circle which one appropriate)

If YES, has it been reported to:

TQCSI – YES NO (Circle which one is appropriate)

Date of Report:	Time of Report:
Name of Officer reported to:	

State Authority – YES NO (circle which one is appropriate)
WHSF 060 – Notifiable Incident Investigation Report Template

Date of Report:	Time of Report:
Name of Officer reported to:	Contact Number:
Report required to be sent: Yes No	Date sent:
Authority Name:	Authority reference no:

Insurance Broker – YES NO (circle which one is appropriate)

Date of Report:	Time of Report:
Name of Officer reported to:	

INCIDENT/INVESTIGATION REPORT

(Office use only)

Completed by Injury Management Coordinator

Incident No:	**Status (Workers Comp Claim / Near Miss / Incident Only):**
Name of injured person:	**Incident report received on:**
Host Employer:	**Investigation report received on:**
Location No:	**Entered onto database: Y N**
Department:	**Date Entered onto Database: Initials:**
Date of Incident:	**Obtained Incident report from Host: Y N N/A Date:**

Actions Commenced: _____/_____/_____	**WHS Risk Assessment conducted Y N** **WHS Risk Assessment current Y N**
Actions Completed: _____/_____/_____	**Report Completed by:**
Follow up information required:	**Date completed: _____/_____/_____** **Comments:**

Notifiable Incident Y N

Notifiable Report Attached: _____

Investigation Officer: _____

Date: _____/_____/_____

Prepared by: Kate Dewsnap