

# Yarra Theological Union

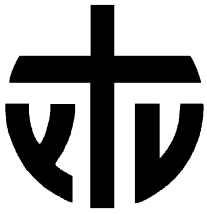
## Incident Report Form

A Recognised Teaching Institution of MCD University of Divinity

**NB: Once completed return to the Registrar's office**

### Section 1: Personal Details and Incident Details

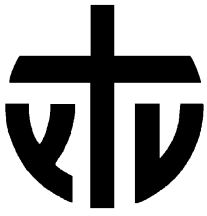
<b>Surname / Family Name</b>	
<b>First Name</b>	
<b>Day and Date of Incident</b>	
<b>Time of Incident</b> (24hr)	
<b>Time Commenced Work</b> (24hr)	
<b>Usual Employment Location</b> (if applicable, e.g.: Classroom 1 Main Building YTU)	
<b>General Location of Incident</b> (e.g. Library, Lower Car park)	
<b>Exact Location of Incident</b> (Give full details-e.g.: at the borrowing desk, next to the western fence)	
<b>Describe the incident or injury.</b> (give full details-e.g.: deep cut on little finger of left hand, slipped on wet floor and fell on back etc.)	
<b>Describe the accident happen and what you were doing at the time of the incident.</b> (Describe in detail what caused the incident. Attach additional information if necessary)	



<b>What protective equipment/clothing if any was being used or worn at the time of the incident?</b> (e.g.: rubber gloves, steel capped boots)	
<b>Describe any medical treatment and or follow up action required after the incident.</b> (e.g.: physio sessions for 6 weeks)	
<b>Were any other persons involved in the incident besides yourself? If yes, please provide details.</b>	

**Section 2: Consequence of Incident**

<b>Injury</b>	<b>Person Affected</b>	<b>Property Damage</b>
<input type="checkbox"/> No Injury	<input type="checkbox"/> Student	<input type="checkbox"/> Building
<input type="checkbox"/> First Aid	<input type="checkbox"/> Employee	<input type="checkbox"/> Tools
<input type="checkbox"/> Medical Treatment	<input type="checkbox"/> Contract Visitor	<input type="checkbox"/> Plant
<input type="checkbox"/> Fatality	<input type="checkbox"/> Other Visitor / Guest	<input type="checkbox"/> Other
<input type="checkbox"/> Lost Time (not able to come to work/study the day after the incident)		



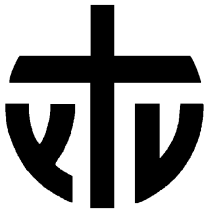
**Section 3: Witness Details**

<b>Witness Name</b>	<b>Personal Contact Details</b> (ph/mobile/email)
1.	
2.	
3.	

**Section 4: Additional Information**

<b>To whom was the Incident Reported? Date and Time</b> (24hr)	
<b>When was the incident reported?</b>	
<b>In your opinion, what action if any, could be taken to prevent the recurrence of the incident</b>	
<b>Was an ambulance called?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes Incident no.
<b>Were the police called</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes Incident no.
<b>Was Trauma Counselling offered</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Was Medical treatment sought</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes

X	x	
<b>Name of person affected by Incident</b>	<b>Signature</b>	<b>Date</b>



**Section 5 Office Use Only**

<b>Office Comments and Investigation Notes</b>	
<b>Office Follow Up Action Required</b>	
<b>Target date for follow-up action</b>	
<b>Will the injured person be off work for more than 7 calendar days?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Have all possible actions been taken to prevent a re-occurrence?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Actions taken report attached</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Company person responsible name and signature</b>	Name:
	Signature:
	Date Signed:

**Important Notes:**

Requirements for reporting incidents vary between states. You should be aware that you may be required to report this incident to your Workers Compensation insurer within 48 hours. In addition you may be required to report this incident to the Workcover Authority. You must keep a record of this incident report for the period of time specified by the Workcover Authority in your state.