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

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

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

Section 2: Consequence of Incident

Injury	**Person Affected**	**Property Damage**
□ No Injury	□ Student	□ Building
□ First Aid	□ Employee	□ Tools
□ Medical Treatment	□ Contract Visitor	□ Plant
□ Fatality	□ Other Visitor / Guest	□ Other
□ Lost Time (not able to come to work/study the day after the incident)		

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Section 3: Witness Details

Witness Name	**Personal Contact Details** (ph/mobile/email)
1.	
2.	
3.	

Section 4: Additional Information

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

X	x	
Name of person affected by Incident	**Signature**	**Date**

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Section 5 Office Use Only

Office Comments and Investigation Notes	
Office Follow Up Action Required	
Target date for follow-up action	
Will the injured person be off work for more than 7 calendar days?	□ Yes □ No
Have all possible actions been taken to prevent a re-occurrence?	□ Yes □ No
Actions taken report attached	□ Yes □ No
Company person responsible name and signature	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.