

## Incident/Accident Investigation Form

**NOTE:** A separate form should be completed for each person injured. This investigation is aimed at identifying causes, not attributing blame. All investigating personnel should be trained in investigation techniques. (Workcover to be notified in writing or by phone as required)

Reference No. \_\_\_\_\_ ☐ Injury ☐ Damage ☐ Near Miss

1. Project: \_\_\_\_\_

### 2. Personal Details

<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Surname	First Name	Other Initials
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input style="width: 95%;" type="text"/>
Date of Birth Day/ Month/ Year	Gender M/F	Preferred Language Contact No.

### 3. Occupation/Job Title & Details

<input style="width: 98%;" type="text"/>	Start date
Description of occupation or job title	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Day Month Year

#### Main tasks performed

Training provided: ☐ General Induction.  
☐ Trade/Industry.  
☐ Project/task specific.  
☐ None of the above.

### 4. Time & Date of Damage/Acc/Near Miss

<input style="width: 90%;" type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
am/pm	Day Month Year

### Time & Date Report Received

<input style="width: 90%;" type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
am/pm	Day Month Year

### 5. Accident Results

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Fatal          | <input type="checkbox"/> Hospital inpatient | <input type="checkbox"/> Doctor only         |
| <input type="checkbox"/> First aid only | <input type="checkbox"/> Property damage    | <input type="checkbox"/> Nil (injury/damage) |

Nature of injury, disease or damage: \_\_\_\_\_

Location of injury, disease or damage: \_\_\_\_\_

### 6. Outcome (Questions to be answered, as information becomes available)

#### Rehabilitation

- ☐ Not Required  
☐ Required

#### Date of Resumption

Short-term alternate duties  
 Permanent alternate duties  
 Normal duties

<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Day	Month	Year

Total number of days lost.

- ☐ Government report completed and sent.  
☐ Investigation undertaken.

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**7. Description of Incident** (include any particular chemical, product, process equipment involved)

What was the worker doing at the time? \_\_\_\_\_

Name/s of witnesses	Signature of worker	Date:

How exactly was the injury, disease or damage sustained?

What happened? (undesired event)

Reconstruct the sequence of events that led to the undesired event.

1.	4.
2.	5.
3.	6.

List contributing factors

**OFFICE USE ONLY:**  
**Outside Investigating**

Person: 

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Name                      Position                      Signature

Date investigation conducted: 

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Day                      Month                      Year

**9. Corrective Action Undertaken:** \_\_\_\_\_

Estimated Cost of Incident: \$	Estimated Cost of Correction: \$
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**10. Manager's Comments:** (manager, employer or Principal Contractor to sign and date)

Enter on to Incident/Accident Register: Yes ☐ No ☐

Signature:	Date:
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**11. Status, comments & Verification this issue has been actioned**

**satisfactorily:** (comments, sign and date when closed)

Specialised Geo Pty Ltd OHSR & E Manager Signature:	Close Out Date:
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