

Incident and Work Related Illness/Injury Report



PART A To be completed by employee, student, visitor or contractor

Personal Details

Title:	Family Name:	First Name:	Staff/student number:
Email:	Phone (w):	Phone (h):	Mobile:
Faculty/Division:		School/Unit:	
<input type="checkbox"/> Employee	<input type="checkbox"/> Student	<input type="checkbox"/> Contractor	<input type="checkbox"/> Visitor Other:
Position:	Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Residential address:			

Incident details

Tick one box only	<input type="checkbox"/> Incident with no injury or illness	<input type="checkbox"/> Work related illness	<input type="checkbox"/> Work related injury
Date incident occurred:	/ /	Time of incident:	am/pm
Date of onset of symptoms (if applicable):	/ /		
Date incident reported:	/ /	To whom was the incident first reported:	
Incident location:	<input type="checkbox"/> On campus	<input type="checkbox"/> Off campus	<input type="checkbox"/> On fieldwork <input type="checkbox"/> On journey to or from work
Describe location of incident as follows: building name, room number or street address or fieldwork site			
Names and contact details of any witnesses:			
Describe how the incident occurred and any contributing factors:			
Attach additional information if space insufficient including sketches and photographs			

Injury details

Complete sections A, B and C if injury/illness occurred

A. Part of body injured

<input type="checkbox"/> ankle, left / right	<input type="checkbox"/> arm, left / right	<input type="checkbox"/> back	<input type="checkbox"/> chest	<input type="checkbox"/> elbow, left / right	<input type="checkbox"/> ear, left / right
<input type="checkbox"/> eye, left / right	<input type="checkbox"/> face	<input type="checkbox"/> fingers	<input type="checkbox"/> foot, left / right	<input type="checkbox"/> hand, left / right	<input type="checkbox"/> head
<input type="checkbox"/> groin	<input type="checkbox"/> knee, left / right	<input type="checkbox"/> leg, left / right	<input type="checkbox"/> lungs	<input type="checkbox"/> mouth	<input type="checkbox"/> neck
<input type="checkbox"/> psychological system	<input type="checkbox"/> shoulder	<input type="checkbox"/> stomach	<input type="checkbox"/> teeth	<input type="checkbox"/> toes	<input type="checkbox"/> wrist, left/right

Other:

B. Nature of injury

<input type="checkbox"/> amputation	<input type="checkbox"/> anxiety	<input type="checkbox"/> asthma	<input type="checkbox"/> bruising/crushing	<input type="checkbox"/> burns	<input type="checkbox"/> concussion	<input type="checkbox"/> depression
<input type="checkbox"/> fracture	<input type="checkbox"/> infectious disease	<input type="checkbox"/> laceration	<input type="checkbox"/> needle-stick	<input type="checkbox"/> OOS	<input type="checkbox"/> poisoning	<input type="checkbox"/> rash
<input type="checkbox"/> sharps injury	<input type="checkbox"/> sprain/strain	<input type="checkbox"/> trauma to joints and ligaments		<input type="checkbox"/> trauma to muscles and tendons		<input type="checkbox"/> zoonoses

Other:

C. Type of incident

<input type="checkbox"/> bending, stretching	<input type="checkbox"/> bit by animal	<input type="checkbox"/> bite/sting by insect	<input type="checkbox"/> chemical exposure	<input type="checkbox"/> contact with cold object	<input type="checkbox"/> contact with hot object	<input type="checkbox"/> electricity
<input type="checkbox"/> falling from same level	<input type="checkbox"/> falling from height	<input type="checkbox"/> hit by animal	<input type="checkbox"/> hitting stationary object	<input type="checkbox"/> lifting	<input type="checkbox"/> noise exposure	<input type="checkbox"/> repetitive muscle injury
<input type="checkbox"/> psychological	<input type="checkbox"/> pulling, pushing	<input type="checkbox"/> radiation exposure	<input type="checkbox"/> struck by moving object	<input type="checkbox"/> sunstroke	<input type="checkbox"/> vehicle accident	<input type="checkbox"/> weather exposure

Other:

Details of treatment and work status

Did you receive First Aid?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of First Aider:
Did you see a doctor?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Yet	Did the doctor issue a WorkCover medical certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did you cease work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date and time of cessation: Date and time of return:
Did you cease study?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date and time of cessation: Date and time of return:
Did you go to hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, state which hospital:

Action

Employee, student, visitor or contractor to complete Part A and send to Supervisor within 1 working day.
Supervisor to complete Part B and distribute copies of form (as per Section 14) within 2 working days of notification of incident.
For students consult academic supervisor or program coordinator.

Signature

I approve the release of the information in this form to approved authorities, which may include medical practitioners, legal representatives, employee associations, insurance companies and WorkCover NSW.

Signature:

Date: / /

Privacy Statement

The personal information you provide on this form is protected by the NSW Privacy and Personal Information Protection Act 1998.
Access to the information you provide is only available to those persons authorised to access the information in the course of their duties to The University of New South Wales.

PART B To be completed by supervisor

Incident number:	Incident date: / /	Incident reported by:
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Immediate incident management response			
<input type="checkbox"/> Security notified on x56666	<input type="checkbox"/> Supervisor notified	<input type="checkbox"/> First Aid Officer notified	<input type="checkbox"/> Floor warden notified
<input type="checkbox"/> Other:			

Contributing factors			
<input type="checkbox"/> Slip/trip/fall hazard	<input type="checkbox"/> Risk assessment incomplete	<input type="checkbox"/> Personal Protective Equipment not worn or not available	<input type="checkbox"/> Insufficient training
<input type="checkbox"/> Lifting equipment not used	<input type="checkbox"/> Workplace ergonomics	<input type="checkbox"/> Electrical hazard	<input type="checkbox"/> Weather
<input type="checkbox"/> Other:			

Risk rating																
The risk rating of an incident is based on a combination of Consequence and Probability. Please complete the following table by referring to the UNSW Risk Rating System available at www.riskman.unsw.edu.au . Circle one option only in each section below.																
Consequence	1	2	3	4	5	Probability	A	B	C	D	E	Risk Rating	Low	Medium	High	Extreme

Corrective Action Plan		
To complete the following Corrective Action Plan use the following Hierarchy of Risk Controls. Give priority to eliminating the hazard.		
1. Eliminate	2. Substitute	3. Engineering control
4. Administrative control	5. Personal Protective Equipment	
Actions recommended to be taken	By whom	By when
A.		
B.		
C.		
D.		

Help
In the first instance contact your Supervisor, your OHS Representative or your OHS Committee Chairperson. The Risk Management Unit may be contacted by phone on 93851565 or by fax on 93852365 for OHS & Environment or on 93851107 or by fax on 96634203 for Workers Compensation

Send copies to:
<ol style="list-style-type: none"> 1. Send original report to Manager, Workers Compensation, RMU 2. Forward copies to the following: <ol style="list-style-type: none"> a. Chairperson of your Workplace OHS Committee or OHS Representative b. Faculty/Divisional OHS Coordinator (if applicable) c. Manager, OHS & Environment, RMU d. Retain copy in your School/Divisional Unit Incident Register

Signature
I approve the release of the information in this form to approved authorities, which may include medical practitioners, legal representatives, employee associations, insurance companies and WorkCover NSW.
Supervisor's name: _____ Supervisor's signature: _____ Date: / /
Contact phone number: _____ email address: _____

Office use only

Incident database	/	/	OHS staff site investigation	/	/
WorkCover notified	/	/	OHS Committee investigation	/	/