**DETAILS OF PERSON COMPLETING THIS FORM**

**INCIDENT REPORT FORM**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Person Involved in Incident** | [ ]   | **AFLSR Staff Member or Trainee** | [ ]   | **Supervisor/Host Employer**  | [ ]   | **Contractor/Visitor** | [ ]   |
| Surname | Given Name(s) | Work Ph No:  |
| Role Title:  | Organisation: | Mobile Ph No |

**DETAILS OF PERSON INVOLVED IN INCIDENT**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | [ ]   | **Staff Member/Trainee**  | [ ]   | **Contractor** | [ ]   | **Visitor** |
| Surname | Given Name(s) | Date of Birth | Sex  |
|  |  |  |  |
| Home Address | Home Ph No |
|  |       |
| Employer or Host Employer Name:  | Position Title | Supervisor’s Name |
|  |  |  |
| Site Address: | Work Ph No |
|  |       |

**INCIDENT DETAILS**

|  |  |
| --- | --- |
| Type of Report | Place / location of Incident |
| [ ]  | Injury |  |
| [ ]  | Near miss | Date of Incident | Time of Incident | Did you cease work? Date? |
| Type of Incident |       |       am[ ]  / pm [ ]  | Y [ ]  / N [ ]  |       |
| [ ]  | Slip, trip, fall | Who was the incident/near miss reported to?  | Y [ ]  / N [ ]  |
| [ ]  | Manual handling | Witness/es Name | Witness Contact Ph No |
| [ ]  | Struck by object |       |       |
| [ ]  | Motor vehicle  | Have you returned to work? | Date you returned to work | Time you returned to work |
| [ ]  | Chemical | Y [ ]  / N [ ]  |       |       am[ ]  / pm [ ]  |
| [ ]  | Electrical | What duties can you now perform? |
| [ ]  | Other | [ ]   | Pre-injury Duties  | [ ]  | Suitable Duties | [ ]  | Totally Unfit For Any Duties |
| **Incident or Near Miss Summary - how did it happen?** |
|  |
|  |
| **Briefly describe injuries if any** |
|  |
|  |

**TREATMENT DETAILS**

|  |  |  |
| --- | --- | --- |
| Treatment | Treated by | Treatment date |
| [ ]  | First Aid |       |       |
| [ ]  | Doctor’s Visit | Address | Ph No |
| [ ]  | Hospital Visit |       |       |

**DECLARATION**

I certify that the information I have provided is correct. I consent to AFL SportsReady collecting and using my personal information, and/or disclosing these details to medical practitioners, investigators and other experts, for the purpose of assessing and managing any workers compensation claim relating to the incident referred to on this form.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Signature  |  | Name (printed) |  | Date Signed |

**Once completed, please email immediately to** **Cassandra.Boland@aflsportsready.com.au** **and (if the person involved in the incident is a trainee) the relevant Field Officer**