**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**](mailto:Cassandra.Boland@aflsportsready.com.au) **and (if the person involved in the incident is a trainee) the relevant Field Officer**