U3A Rockhampton and District Inc.
ABN 83 907 668 103

Incident Report Form

PART A – Details of the incident

Details of the person completing the report	Name:
	Contact phone number:
	Email address:
	Position: [ ] Committee Member [ ] Coordinator [ ] First Aid Person [ ] Other (give details)

Time and date of	
Type of incident	[ ] Incident [ ] Accident [ ] Near Miss
Location of incident	
Person at venue notified	
U3A committee notified?	[ ] Yes [ ] No Date notified:
Activity being undertaken	[ ] General Meeting [ ] Committee Meeting [ ] Activity (name) [ ] Other (give details)
Brief description of incident or near miss (if insufficient space, please attach a separate incident report)	
Names and contact details for witnesses to the incident	
Was anyone injured	[ ] No (complete Part B) [ ] Yes (complete Part C for each injured person) How many:

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Name of person completing form: **Signature:** ______________________

Date:

N.B. This form is to be treated as "CONFIDENTIAL". Please retain the original and forward a copy to the Safety Management Team.

PART B – Details of injury

Time and date of incident:

N.B. If more than one person has been injured in this incident, please attach an additional part B for each injured person

Details of injured person	Name: Gender: [ ] Male [ ] Female Date of Birth:
Contact Details	Phone: Mobile: Email: Address:
Relationship with U3A	[ ] Member [ ] Visitor [ ] Guest [ ] Other (give details)
Insurance Claim	Will an Insurance claim be lodged? [ ] Yes [ ] No [ ] Unsure
Mechanism of Injury (indicate all relevant)	[ ] Slip/trip/fall [ ] Manual handling [ ] Being hit by falling object [ ] Hitting an object with part of the body [ ] Being hit by moving objects [ ] Exposure to heat /electricity [ ] Exposure to biological agent (including body fluid) [ ] Violence [ ] Other (give details):
Nature of Injury and position of injury (indicate all relevant)	[ ] Sprain/Strain [ ] Fracture [ ] Cuts/Scratch/Abrasion [ ] Bruising [ ] Burn [ ] Bite/Sting [ ] Electrical shock [ ] Other (give details:
Level of treatment required (highest level only)	[ ] No treatment [ ] First Aid [ ] Doctor [ ] Hospital outpatient [ ] Hospital admission [ ] Other (give details):
Details of treatment required (if any)	
Has the injured person been contacted?	[ ] No [ ] Yes By whom:

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Name of person completing form: **Signature:** ______________________

Date:

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PART C – Investigation

Time and date of incident:

Investigation Methods	[ ] Interviews [ ] Written statements [ ] Examination of accident site [ ] CCTV review [ ]Photographs [ ] Other (give details)
Brief Summary of findings (refer to attachments if necessary)	
Causal factors identified Give details	[ ] People: [ ] Equipment/plant: [ ] Environment: [ ] Processes/procedures: [ ] Organisational factors:
Recommendations (refer to hierarchy of controls)	[ ] Elimination: [ ] Substitution: [ ] Isolation: [ ] Engineering: [ ] Administrative: [ ] Personal protective equipment:
Will recommendations eliminate all hazards?	[ ] Yes [ ] No

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Name of person completing form: **Signature:** ________________________

Date: **Date copy submitted to Safety Management Team:**

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PART D – Actions Time and date of incident:
(To be completed by the Safety Management Team)

* N.B. Actions are to be reviewed and approved by the committee of U3A Rockhampton and District Inc.

Confirmation of actions	Are all recommendations accepted? [ ] Yes [ ] No Note exceptions:
Additional actions to be taken	
Actions completed	Are all actions completed? [ ] Yes [ ] No
Update Risk Assessment Form	Has Risk Assessment Form for the venue/activity been updated as soon as possible after the incident? [ ] Yes [ ] No
Communication	Date person reporting incident notified of outcomes: Date committee notified of outcomes: Date copy of complete Incident Report Form sent to Assistant Secretary for filing:

Name: **Signature:** ______________________ **Date:**

Date reviewed by Committee:

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PART E – Follow up Report (to be completed on on-going basis)
(To be completed by the Safety Management Team)

*

Details of injured person	Name: Gender: [ ] Male [ ] Female Date of Birth:
Contact Details	Phone: Mobile: Email: Address:
Details of Accident	Date: Time: Place:
Details of injury	
Has an insurance claim been lodged?	[ ] Yes [ ] No If Yes, complete details below. Type of claim – [ ] Public Liability [ ] Accident Insurance Name of solicitor: Contact details of solicitor:
Progress of claim	
Result of claim	

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Name of person completing form: **Signature:** ______________________

Date: **Date copy submitted to Safety Management Team:**

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