all about you
disability services

ABN 52 114 261 461

Incident Report

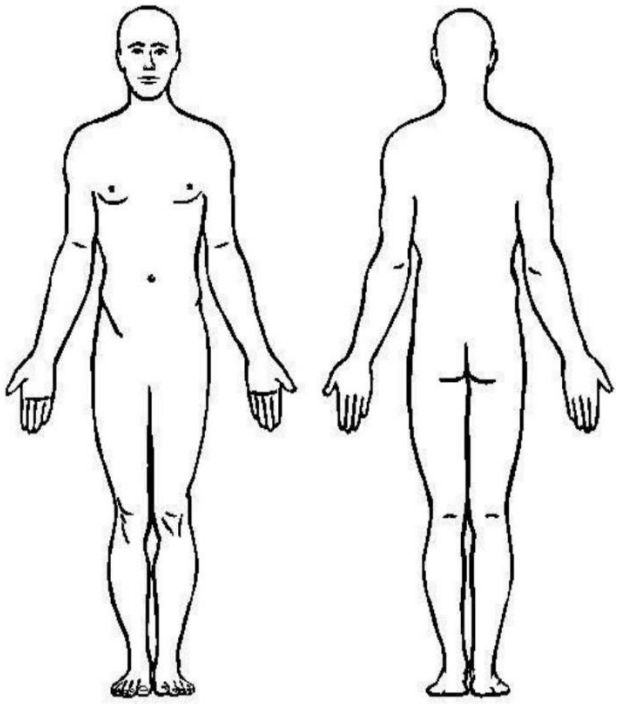
This form is to be completed for **all incidents, injuries or illnesses, regardless of the extent or to whom the incident occurred** and submitted as soon as practicable, but no later than 24 hours after the incident.

The Manager/Supervisor is to complete their section within 24 hours of the incident being reported.

NDIS Commission reportable incident	☐ Yes	☐ No

Employee to complete			
Employee name			
Participant name			
Type of incident *(please select one)*	☐ Near miss ☐ Injury ☐ Illness ☐ Property damage ☐ Other *(please specify):*		
Date of incident		Time of incident	
Date incident reported		Time incident reported	
Status of affected person	☐ All About You – Disability Services employee ☐ All About You – Disability Services participant ☐ Other *(please specify):*		

Where were you when the incident occurred *(please provide a location)*	
What were you doing at the time of the incident *(ie manual handling, active support, cleaning etc)*	
Provide a brief description of the incident *(ie what were the circumstances and what injury, if any, was sustained)*	
Were there any witnesses	☐ Yes ☐ No *if Yes, please provide details below.*
	Witness name/phone
	Witness name/phone
What do you think could be done to prevent this incident occurring again	

Personal injury locations *(please select all that apply)*	*Please indicate with an X where incident occurred on body* ☐ Eye ☐ Ear ☐ Face ☐ Head ☐ Neck ☐ Back ☐ Torso ☐ Shoulders & arms ☐ Hands & fingers ☐ Hips & legs ☐ Feet & toes ☐ Muscular/Internal ☐ General and unspecified areas 
Please provide any further details relevant to the injury	
Could this incident have resulted on death, serious injury or both	☐ Yes ☐ No *If Yes, was the incident reported to:* ☐ Manager ☐ Other *(please specify)*:

Signature		Date	

Manager/Supervisor to complete	
Outcome of incident *(please select all that apply)*	☐ No injury ☐ First aid applied ☐ Returned to normal duties ☐ Medical treatment required (Doctor/Hospital) ☐ Injury (returned to alternate duties) ☐ Serious injury (off work) ☐ Permanent injury ☐ Property damage
Brief description of immediate preventative action taken	
Is an investigation required	☐ Yes ☐ No *If Yes, an Incident Investigation Form will need to be completed.*
Have the relevant people been notified that the incident occurred	☐ Yes ☐ No *if Yes, please provide details below.*
Name	
Position	
Name	
Position	

What can be done to prevent future incidents of this nature	

Has the employee received the appropriate documentation	Workers Compensation form/s: ☐ Yes ☐ No Copy of Incident Report form: ☐ Yes ☐ No *If No, please provide details of the reason/s why:*

Further details, including any follow up action/s	

Signature		Date	