# **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.

TheManager/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 |  |