# **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 [ ]  NoCopy 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 |  |