

AUSTRALIAN CLAY TARGET ASSOCIATION INC INCIDENT REPORT FORM



This form is to be used to report all injuries, illnesses, or near misses, whether an injury occurred or not, and to document the investigation.

Please complete within 24 hours of the incident.

SECTION A: TO BE COMPLETED BY PERSON INVOLVED

PERSON INVOLVED

Title	Surname	First Name	Date of Birth

<input type="checkbox"/> Staff	<input type="checkbox"/> Volunteer	<input type="checkbox"/> Member	<input type="checkbox"/> Visitor/Other
--------------------------------	------------------------------------	---------------------------------	--

Contact Number	Occupation	Industry

Injured Person's Address

DETAILS OF THE:-

- INJURY
 - NEAR MISS
 - INCIDENT
- (Tick appropriate box)

Date injury/incident/near miss occurred: ___ / ___ / ___
 Time injury/incident/near miss occurred: _____ am/pm

Location where injury/incident occurred

Part of body affected (tick appropriate answers)

<u>Head</u>	<u>Trunk</u>	<u>Internal</u>	<u>Arm</u>	<u>Hand</u>	<u>Leg</u>	<u>Foot</u>
<input type="checkbox"/> Eye	<input type="checkbox"/> Neck	<input type="checkbox"/> Heart	<input type="checkbox"/> Left	<input type="checkbox"/> Left	<input type="checkbox"/> Left	<input type="checkbox"/> Left
<input type="checkbox"/> Ear	<input type="checkbox"/> Hip	<input type="checkbox"/> Lungs	<input type="checkbox"/> Right	<input type="checkbox"/> Ear	<input type="checkbox"/> Right	<input type="checkbox"/> Right
<input type="checkbox"/> Nose	<input type="checkbox"/> Chest	<input type="checkbox"/> Systemic	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Nose	<input type="checkbox"/> Knee	<input type="checkbox"/> Great
<input type="checkbox"/> Mouth	<input type="checkbox"/> Stomach		<input type="checkbox"/> Upper	<input type="checkbox"/> Mouth	<input type="checkbox"/> Lower	<input type="checkbox"/> Toe
<input type="checkbox"/> Teeth	<input type="checkbox"/> Groin		<input type="checkbox"/> Arm	<input type="checkbox"/> Teeth	<input type="checkbox"/> Leg	<input type="checkbox"/> Other
<input type="checkbox"/> Face	<input type="checkbox"/> Back		<input type="checkbox"/> Elbow	<input type="checkbox"/> Face	<input type="checkbox"/> Ankle	<input type="checkbox"/> Toes
<input type="checkbox"/> Skull	<input type="checkbox"/> Multiple		<input type="checkbox"/> Forearm	<input type="checkbox"/> Skull	<input type="checkbox"/> Thigh	
			<input type="checkbox"/> Wrist		<input type="checkbox"/> Upper	
					<input type="checkbox"/> Leg	

Nature of Injury (tick appropriate answers)

<input type="checkbox"/> Abrasion	<input type="checkbox"/> Bite	<input type="checkbox"/> Hernia	<input type="checkbox"/> Aggravation of Previous Injury or Medical Condition
<input type="checkbox"/> Bruise	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Burn	<input type="checkbox"/> Not Applicable
<input type="checkbox"/> Fracture	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Scald	<input type="checkbox"/> Electric Shock
<input type="checkbox"/> Concussion	<input type="checkbox"/> Foreign Body	<input type="checkbox"/> Rash	
<input type="checkbox"/> Puncture	<input type="checkbox"/> Minor Cuts	<input type="checkbox"/> Allergy	
<input type="checkbox"/> Laceration	<input type="checkbox"/> Sprain	<input type="checkbox"/> Traumatic Shock	
<input type="checkbox"/> Amputation	<input type="checkbox"/> Strain	<input type="checkbox"/> Psychosocial	
<input type="checkbox"/> Aggravation		<input type="checkbox"/> Chemical	

Type of Incident which caused Injury (tick appropriate answers)

<input type="checkbox"/> Striking Against	<input type="checkbox"/> Stumbling	<input type="checkbox"/> Bending	<input type="checkbox"/> Jumping
<input type="checkbox"/> Struck By	<input type="checkbox"/> Slipping	<input type="checkbox"/> Twisting	<input type="checkbox"/> Motor Vehicle
<input type="checkbox"/> Caught In	<input type="checkbox"/> Tripping	<input type="checkbox"/> Stress	<input type="checkbox"/> Ingestion
<input type="checkbox"/> Stepped On	<input type="checkbox"/> Falling	<input type="checkbox"/> Pushing	<input type="checkbox"/> Absorption
<input type="checkbox"/> Other: Describe	<input type="checkbox"/> Lifting	<input type="checkbox"/> Pulling	<input type="checkbox"/> Inhalation
<input type="checkbox"/> Not Applicable			

Agency of Injury/Illness/near miss (tick)

<input type="checkbox"/> Vehicle	<input type="checkbox"/> Buildings	<input type="checkbox"/> Mobile Plant	<input type="checkbox"/> Structures
<input type="checkbox"/> Power Tools	<input type="checkbox"/> Furniture	<input type="checkbox"/> Other Tools	<input type="checkbox"/> Surfaces
<input type="checkbox"/> Animal/Insect	<input type="checkbox"/> Heat Stress	<input type="checkbox"/> Materials	<input type="checkbox"/> Sunburn
<input type="checkbox"/> Biological Agent	<input type="checkbox"/> Chemicals	<input type="checkbox"/> Equipment	<input type="checkbox"/> Stress
<input type="checkbox"/> Not Applicable			<input type="checkbox"/> Other

If reporting an incident or near miss, please describe how this occurred:

SECTION B: TO BE COMPLETED BY THE SUPERVISOR & THE PERSON INVOLVED WITHIN 48 HRS

This is an extremely important section as the aim of the incident investigation is to identify preventative action that will avoid recurrence.

Probable cause or causes of Injury / Incident (tick appropriate answers)

<input type="checkbox"/> Inadequate Instruction	<input type="checkbox"/> Fault of Plant or Equipment	<input type="checkbox"/> Poor Storage	<input type="checkbox"/> Weather
<input type="checkbox"/> Inadequate Workspace	<input type="checkbox"/> Equipment Unavailable	<input type="checkbox"/> Poor Access	<input type="checkbox"/> Terrain
<input type="checkbox"/> Assistance Unavailable	<input type="checkbox"/> Lack of Attention	<input type="checkbox"/> Incorrect Method	<input type="checkbox"/> Work Practices

Describe how the incident occurred:

PREVENTION OF INCIDENT RECURRENCE

Describe what action is planned or has been taken to **prevent a recurrence** of the incident, based on the key contributing factors

SECTION C:

Signed by supervisor	_____
Supervisor's name	_____
Signed by person involved	_____
Signed by senior manager	_____
Date	_____