WORKPLACE INCIDENT REPORT FORM

Workplace / Location: _____ Time of Incident: _____

Reporter Details:

Full Name: _____

Position / Job Title: _____

Contact Phone / Email: _____

Person(s) Involved in Incident:

Full Name(s): _____

Position(s) / Job Title(s): _____

Contact Phone / Email(s): _____

Incident Details:

Date of Incident: _____

Exact Location of Incident: _____

Type of Incident (tick all that apply):

- ☐ Injury
- ☐ Near Miss
- ☐ Property Damage
- ☐ Environmental
- ☐ Other

Describe the Incident (what happened, how, contributing factors):

Injury Details (if applicable):

Nature of Injury: _____

Body Part(s) Affected: _____

Was medical treatment required? _____

Immediate Actions Taken:

REPORTER'S SIGNATURE	INVESTIGATOR'S SIGNATURE
Date:	Date:
Signature: _____	Signature: _____

This Workplace Incident Report Form is intended to comply with applicable Australian workplace health and safety laws. The information provided will be treated confidentially and used for the purpose of incident management, prevention, and regulatory compliance. Completion of this form does not constitute an admission of liability.