

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.

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