CHALLENGE BATHURST INCIDENT/HAZARD REPORT

Incident No.....

This Report is to be completed by the individual identifying the incident/hazard and given to your Supervisor at end of the day. If, however, the incident has resulted in an injury requiring medical assistance (or is a hazard potentially resulting in serious injury), this Report is to be provided to the Event Management Office immediately.

THIS IS A REPORT OF: (Please circle one only)

A	Injury	First Aid or Medical Treatment Only
B	Injury	Medical Treatment and Lost Time
C	Injury	No First Aid or Treatment Required
D	Hazard	Complete Section 2 and 6 Only
E	Incident	No injury or damage (i.e. near miss), complete Section 2 and 3

OFFICE USE ONLY
DEPARTMENT:
TYPE:

ARE YOU: (Please circle)

A	Permanent Employee	E	Temporary Employee	I	Competitor
B	Part Time Employee	F	Contractor	J	Member of the Public
C	Full Time Employee	G	Visitor	K	Other (please specify)
D	Casual Employee	H	Official or Volunteer		.....

SECTION 1 – DETAILS OF INJURED PERSON:

Name:	Contact Phone No:
Address:	
Job Title:	Supervisor:
Section:	Commencement Date:

Male/Female:	Payroll No:	Date of Birth:

SECTION 2 – DETAILS OF PERSON COMPLETING FORM
(if same as Section 1, enter "As Above"

Name:	Contact Phone No:

SECTION 3 – INCIDENT/NEAR MISS/HIT DETAILS:

Incident Date:	Incident Time: am/pm
Incident Location:	
Is this the usual workplace for this employee?	YES / NO
How did the incident occur?	

Date Notice Given:	Time Notice Given:	Reported To:
Did You Cease Work?	Date Ceased Work:	Time Ceased Work:

SECTION 4 – FIRST AID DETAILS:

Name of person providing first aid:	Contact Phone No:
Details to first aid treatment given:	

SECTION 5 – INJURY DETAILS: Body Part Injured: (please indicate below)

Circle if Applicable:	LEFT	RIGHT						
	Back		Finger/Thumb		Eye		Nose	
	Neck		Hand		Toe		Respiratory System	
	Shoulder		Wrist		Foot		Head	
	Trunk		Elbow		Ankle		Other (please specify)	
	Groin		Arm		Knee			
					Leg			

Nature of Injury: (please indicate if known)							
	Fracture		Burn/Scald		Sprain/Strain		Bite-from insect
	Crush		Electric Shock		Concussion		Bite-from animal
	Dislocation		Deafness		Bruise/Swelling		Bite-from human
	Abrasion/Laceration		Puncture Wound		Amputation		Other (please specify)
	Allergic Reaction		Foreign Body		Infection/Infestation		

Tick the box(es) that best describe the incident:					
	Fall to same level		Stretching/over reaching		Long term exposure to sun
	Fall to different level		Twisting		Electric Shock
	Hit by object		Jarring		Exposure to extreme cold/heat
	Hit against object		Prolonged repetitive movement		Exposure to chemicals, dust or gas
	Stepped on object		Prolonged work in one position		Mental Stress
	Caught in/between object		Prolonged vibration		Motor vehicle accident
	Lifting		Long term exposure to noise		Act of aggression by other person
	Pushing		Sudden loud noise		Other (please specify)
	Pulling		Contact with vermin, insects etc		

In your opinion, what could be done to prevent this type of incident?

Names and contact details of witnesses to the incident:

SECTION 6 – HAZARD DETAILS:

Identified Hazard:

What could be or has been done to eliminate the hazard?

Note: If there is a risk of death or injury, please contact your Supervisor immediately.

If you are the person affected or reporting the incident or illness ***you have now completed the incident/hazard report****. Please take a minute to check the form and make sure you have completed it correctly. Then* ***sign the form and deliver it to your Supervisor*** *for their signature.*

Should you have any enquiries regarding the completion of this form please contact the Event's ***WHS Co-Coordinator on 6333 1600.***

Attach a diagram if necessary: Attached YES NO

Your Name:	Your Signature:	Date:
Supervisor's Name:	Supervisor's Signature:	Date:

You may take a photocopy of this report for your personal reference

NOTE: ***The completion of this form is not a claim for Workers Compensation****.*