



**INSTRUCTIONS: Complete and send to the Director, People and Culture within 24 hours of the incident occurring**

Email [Beatrice.Lorquet@excelsia.edu.au](mailto:Beatrice.Lorquet@excelsia.edu.au) to notify of forms being dropped off or emailed.

**If an incident occurs on a weekend, fax by 9am on the Monday following the weekend.**

Private Note: The information collected on this form is used for the reporting of incidents to Excelsia College, its insurers and government agencies as required by law

**Section 1: To be completed for all incidents including near misses**

Reported By: _____	Position: _____	Signature: _____
Telephone: _____	Date Incident Occurred: ____/____/____	
Time (in 24-hour format, e.g. 1530 instead of 3:30pm): _____		Date Incident Reported: ____/____/____
Reported To: _____	Location of Incident: _____	
Brief Description of Incident: <small>(Just record facts, not opinion or hearsy)</small>		
Initial Action Taken: <small>(Include names of parents/guardians contacted etc.)</small>		
If there were witnesses, please provide their details here:		
Surname: _____	Given name: _____	Home Phone: _____
Work Phone: _____	Email: _____	Address: _____
Surname: _____	Given name: _____	Home Phone: _____
Work Phone: _____	Email: _____	Address: _____
Emergency Services: <input type="checkbox"/> Police <input type="checkbox"/> Fire Brigade <input type="checkbox"/> Ambulance		
Station: _____                      Contact Officer: _____                      Event No. _____		
Outcome:	<input type="checkbox"/> Near Miss	<input type="checkbox"/> Sexual Assault
	<input type="checkbox"/> Theft or Financial Loss	<input type="checkbox"/> Service Disruption
	<input type="checkbox"/> Physical Injury (complete section 3)	<input type="checkbox"/> Other Property Damage or Loss
	<input type="checkbox"/> Psychological Injury (complete section 3)	<input type="checkbox"/> Illness or Disease (Section 3)
	<input type="checkbox"/> Challenging behavior (complete section 4)	<input type="checkbox"/> Medication Related
	<input type="checkbox"/> Motor Vehicle Damage Rego No: _____ (complete motor vehicle accident claim form)	

**Signature:**

I approve the release of the information in this form to approved authorities, which may include medical practitioners, legal representatives, employee associations, insurance companies and WorkCover NSW

Your Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Department Head: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**Section 2: Complete for incidents involving physical or psychological injury, illness or disease**

Name of injured person: \_\_\_\_\_  Male  Female  
 Residential Address: \_\_\_\_\_ Email: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
 Interpreter Required:  Yes  No Language: \_\_\_\_\_ Occupation of injured person: \_\_\_\_\_  
 Employee Status:  Full Time Employee  Part Time Employee  Casual Employee Employee ID: \_\_\_\_\_  
 Volunteer  Student  Visitor  Contractor  Client/Resident/Patient/Service User  
 Where did the injury/illness occur?  At work  On the way to or from work  During a break at work (lunch)  
 Other: \_\_\_\_\_

<p><b>Nature of Injury:</b></p> <input type="checkbox"/> Head Injury <input type="checkbox"/> Fractures <input type="checkbox"/> Amputation <input type="checkbox"/> Laceration <input type="checkbox"/> Sharp, needle stick <input type="checkbox"/> Superficial Injury <input type="checkbox"/> Bruising or Crushing <input type="checkbox"/> Burns <input type="checkbox"/> Sprains and Strains <input type="checkbox"/> Foreign body <input type="checkbox"/> Electric shock/electrocution <input type="checkbox"/> Heat Stress, heat stroke <input type="checkbox"/> Occupational Overuse <input type="checkbox"/> Anxiety, Stress <input type="checkbox"/> Short term shock/distress <input type="checkbox"/> Hernia <input type="checkbox"/> Dermatitis, other skin diseases <input type="checkbox"/> Infectious Diseases <input type="checkbox"/> Cancer <input type="checkbox"/> Multiple Injuries <input type="checkbox"/> Other: _____ _____ _____ _____	<p><b>Mechanism:</b></p> <input type="checkbox"/> Falls from a height <input type="checkbox"/> Trips and slips <input type="checkbox"/> Stepping, sitting on objects <input type="checkbox"/> Hitting objects with body <input type="checkbox"/> Being hit by objects <input type="checkbox"/> Sound or pressure <input type="checkbox"/> Lifting or carrying <input type="checkbox"/> Repetitive movement with low muscle loading <input type="checkbox"/> Other muscular stress <input type="checkbox"/> Contact with heat, cold, electricity, radiation <input type="checkbox"/> Contact with substance <input type="checkbox"/> Insect bites, stings <input type="checkbox"/> Exposure to biological agents (non-human) <input type="checkbox"/> Exposure to blood or bodily fluids <input type="checkbox"/> Exposure to traumatic event <input type="checkbox"/> Vehicle Accident <input type="checkbox"/> Other: _____ _____ _____ _____	<p><b>Agency:</b></p> <input type="checkbox"/> Machinery, fixed plant <input type="checkbox"/> Mobile Plant <input type="checkbox"/> Motor Vehicles <input type="checkbox"/> Workshop, worksite tools <input type="checkbox"/> Kitchen Equipment <input type="checkbox"/> Office Equipment <input type="checkbox"/> Outdoor Powered Equipment <input type="checkbox"/> Other Powered Equipment <input type="checkbox"/> Knives, hand operated cutters <input type="checkbox"/> Other tools <input type="checkbox"/> Furniture and fittings <input type="checkbox"/> Cutlery and utensils <input type="checkbox"/> Ladders, scaffolding <input type="checkbox"/> Other non-powered equipment <input type="checkbox"/> Chemicals, substances <input type="checkbox"/> Outdoor environment <input type="checkbox"/> Indoor office environment <input type="checkbox"/> Live animals <input type="checkbox"/> Dead animals, carcasses <input type="checkbox"/> Human agencies <input type="checkbox"/> Biological agencies <input type="checkbox"/> Other: _____ _____ _____ _____	<p><b>Location:</b></p> <input type="checkbox"/> Eye <input type="checkbox"/> Ear <input type="checkbox"/> Mouth <input type="checkbox"/> Nose <input type="checkbox"/> Face <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Trunk <input type="checkbox"/> Shoulders, arms <input type="checkbox"/> Hands, fingers <input type="checkbox"/> Hips, legs <input type="checkbox"/> Feet, toes <input type="checkbox"/> Circulatory System <input type="checkbox"/> Respiratory System <input type="checkbox"/> Digestive System <input type="checkbox"/> Genitals, urinary system <input type="checkbox"/> Nervous System <input type="checkbox"/> Multiple Locations <input type="checkbox"/> Other: _____ _____ _____ _____
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Treatment Administered:  None  First Aid  Off-Site Medical Treatment (give details below)

Name of Doctor/Hospital: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Is there likely to be time lost?  Yes  No If yes, estimate of days to be lost: \_\_\_\_\_

(If an employee has off-site medical treatment or time off work, a workers compensation claim form must be completed)

### Risk Corrective Action Plan

**Assess the Risk:**  
 What is the Identified Hazard?  
 What is the risk being controlled?  
 The risk rating of hazard is based on a combination of Consequence and Likelihood. Please complete the following table by referring to **Risk Assessment Chart**. Record the Level of Risk Here (e.g. A1-Critical): \_\_\_\_\_

**Corrective Action Plan:**  
 The Supervisor is responsible for ensuring corrective actions are entered on the Corrective Actions Register, completed and of notifying the person completing section 1. The Head of School is responsible for supervisors completing corrective actions in a timely manner.

Corrective Actions to be taken (must be used in this order when possible)	By Whom	By When
Eliminate the hazard or risk by:		
Substitute with something less hazardous:		
Engineering controls (e.g. hand truck, trolley, machine guarding, fume cupboard)		
Administrative controls (signage, safe working procedure, risk assessment, training)		
Personal protective Clothing & equipment		

**A combination of the above measures may be required to be taken to minimize the risk to the lowest level reasonably practicable if no single measure is sufficient for that purpose.**

Please explain why you have not used controls higher up the hierarchy of risk controls if applicable:

### Section 3: Head Office Use

Date Received by HR: \_\_\_/\_\_\_/\_\_\_

Internal Notifications:  Legal  Property and Development  Clinical Support  Other: \_\_\_\_\_

Director, People and Culture: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Chief Executive: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Risk Rating		Consequence Rating			
		<b>Catastrophic</b> Fatality, permanent disability or life-long illness	<b>Major</b> Time off work or class	<b>Minor</b> First Aid Treatment	<b>Negligible</b> No injury
Likelihood Rating	<b>Almost Certain</b> (10+ Times per Year)	<b>A1</b> <b>CRITICAL</b>	<b>A2</b> <b>CRITICAL</b>	<b>A3</b> <b>HIGH</b>	<b>A4</b> <b>MODERATE</b>
	<b>Likely</b> (At least 1 Time per Year)	<b>B1</b> <b>CRITICAL</b>	<b>B2</b> <b>CRITICAL</b>	<b>B3</b> <b>MODERATE</b>	<b>B4</b> <b>MODERATE</b>
	<b>Unlikely</b> (Once every 100 Years)	<b>C1</b> <b>HIGH</b>	<b>C2</b> <b>MODERATE</b>	<b>C3</b> <b>LOW</b>	<b>C4</b> <b>LOW</b>
	<b>Rare</b> Only in extreme circumstances	<b>D1</b> <b>HIGH</b>	<b>D2</b> <b>MODERATE</b>	<b>D3</b> <b>LOW</b>	<b>D4</b> <b>LOW</b>