HAZARD, INCIDENT & DANGEROUS OCCURANCE FORM

This form is to report all workplace incidents & near misses whether or not they result in injury, loss or damage. All incidents shall be reported immediately.

Incident Type: **Near Miss** ☐ **Injury** ☐ **Damage** ☐ **Rail Incident** ☐ **Illness** ☐

Severity: **First Aid Injury** ☐ **Medically Treated Injury** ☐ **Lost Time Injury** ☐

Details of Injured Person or Person Involved in Incident/Near Miss:

Name:		Birth Date:		Sex: M/F
Company:	Track Safety Australia	Site:		
Address:		Postcode:		
Contact No:		Employment Type:		

Details of Incident:

Address of Incident:			
Location of Incident:		On Site Location:	
Date of Incident:		Time of Incident:	
Date Reported:		Time Reported:	

Train Number:		Wagon Number:	
Rail Operator:		Operated By:	
Customer Name & Details:			

Incident Category (*Rail only*)	Category A Occurrence ☐	Category B Occurrence ☐	Un-Reportable Occurrence ☐	
Is this a Notifiable Incident/Event?	Yes ☐	No ☐		
Have Authorities been notified?	Yes ☐	No ☐	Which Authority:	
Dangerous Goods Involved	Yes ☐	No ☐	List Chemicals:	
Drug & Alcohol test conducted post incident: Yes ☐ No				

Incident Reported to: Name:	Position:	Phone Number:
Name of Witness:	Position:	Phone Number:

Detailed Description of What Happened: (Please attach additional details, photos, reports etc.)
Immediate Control Measures Put In Place: (If rail incident, confirm control measures with rail operator)

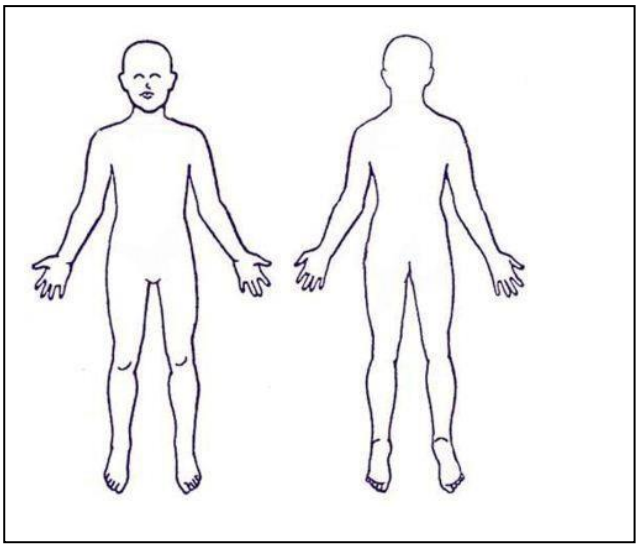
Description of Injury:

***** Please indicate location of injury on reference.**

Body Location:

Injury Type:

No Apparent Injury	☐	Hand Vibration	☐
Abrasion	☐	Hernia	☐
Amputation	☐	Internal Injury	☐
Breathing Difficulties	☐	Laceration	☐
Burn / Scald	☐	Penetrating Injury	☐
Concussion	☐	RSI	☐
Deafness	☐	Eye Injury	☐
Dermatitis/Eczema	☐	Soft Tissue Injury	☐
Dislocation (joints)	☐	Sprain	☐
Illness	☐	Strain	☐
Fatality	☐	Superficial Injury	☐
Fracture	☐		



Cause of Injury:

Contact with Electricity	☐	Exposure to Radiation	☐		
Contact with Moving Machinery	☐	Exposure to Weather Elements	☐	Injured by Animal or insect	☐
Drowned or Asphyxiated	☐	Exposure to Harmful Substance	☐	Injured while Lifting / Carrying	☐
Exposure to Explosion	☐	Fall From Height	☐	Other Kind of Accident	☐
Exposure to Fire	☐	Fall, slip or Trip	☐	Physically Assaulted	☐
Exposure to Heat / Cold	☐	Fatigue	☐	Repetitive Movement	☐
Exposure to Mental Stress	☐	Hit by Moving Vehicle	☐	Trapped by Collapse	☐
Exposure to Noise / Sound	☐	Hit by Flying or Falling Object	☐	Record only Event	☐
Exposure to Pressure	☐	Hit by something Fixed	☐		

Did the Person:

Become unconscious ☐ Need Resuscitation ☐ Remain in Hospital for more than 24hrs ☐ None of These ☐

Treatment Given:

First Aid ☐ Ambulance ☐ Visit to Doctor ☐ Visit to Hospital ☐ None of These ☐

First Aiders Name:_____ Contact No: _____

Hospital / Medical Facility Attended: _____

Form Completed By: _____ Signature: _____ Date: _____

Supervisor Name:_____ Signature: _____ Date: _____

Immediate Manager notified: Mgr Name:_____ Time: _____