Date of issue:	

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INCIDENT / NEAR-MISS REPORT FORM 5.2.b

In case of an emergency:

- Contact emergency services: 111
- Call WorkSafe: 0800 030 040

Personal details

NAME:	PHONE NUMBER:
ADDRESS:	DATE OF BIRTH:
	SEX: ○ Male ○ Female

Employment details

FARM NAME:		JOB TITLE:	
○ Permanent	○ Casual	○ Contractor	○ Visitor

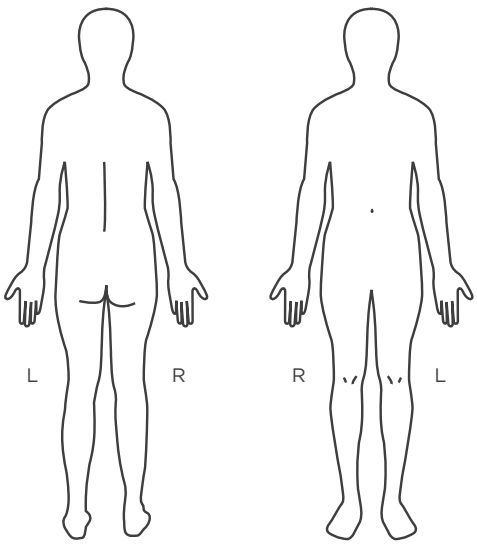
Accident details

DATE:	○ Near-miss	○ No treatment	○ First aid	○ Doctor	○ Hospital	○ Serious harm
TIME:	○ AM	○ PM	Hours at work:		Date reported:	

Nature of injury

○ Strain/sprain	○ Cut	○ Head injury	○ Fracture/break	○ Gradual process
○ Bruising	○ Burns	○ Poison/chemical	○ Multiple injuries	○ No injury

LOCATION OF INJURY (CIRCLE LOCATION)



Back Front

WHERE DID THE ACCIDENT HAPPEN? (EG SHED, PADDOCK ETC)

HOW DID THE ACCIDENT HAPPEN?

WAS THE PERSON TRAINED FOR THE TASK THEY WERE DOING?	○ Yes	○ No
IF A VEHICLE WAS INVOLVED, RECORD TYPE OF VEHICLE		
WAS A SIGNIFICANT RISK INVOLVED?	○ Yes	○ No
IF YES, WHAT WAS THE SIGNIFICANT RISK?		
IS THE RISK ON THE RISK REGISTER?	○ Yes	○ No

WHAT HARM COULD HAVE HAPPENED?

STEPS TAKEN TO PREVENT A SIMILAR EVENT HAPPENING AGAIN

SPECIFIC ACTIONS REQUIRED	PERSON RESPONSIBLE	BY WHEN	DATE COMPLETED

INITIAL NEEDS ASSESSMENT (ONLY COMPLETE IF A DOCTOR'S VISIT WAS REQUIRED)		
○ Able to continue full duties	○ Able to do light duties	○ Unable to work
○ Help available at home	○ Assistance required at home	○ Transport assistance needed

Form completed by	
NAME:	**POSITION:**
SIGNED:	**DATE FORM WAS COMPLETED:**