



INCIDENT REPORT

For completion by Safety Officer

Details:						
WORKPLACE LOCATION					REF #	
					DATE	
REPORTED BY				TIME REPORTED		
TIME OF						
Personnel						
NAME				POSITION		
EMAIL				D.O.B		
STATUS	Contractor	Volunteer	Staff	Visitor	(please circle)	
EMPLOYER				Phone:		
CONTACT			EMAIL:			
Nature of incident e.g. collision, fall, near miss etc						
Damage to property or infrastructure						
Activity in which the person was engaged at the time of incident						
Treatment Provided by First Aid Officer Yes/No				Details		
Control Measures Required Yes/No				If yes, what are they		
Implemented by			Date implemented			
Name Of Witness						
Email				Phone		
Name of Person Completing form						
Email				Phone		
COMMENTS						
						SIGNED