
INCIDENT REPORTING FORM

FOR YOUR CRICKET CLUB

August 2016



INCIDENT

Incident date:		What time did it happen?	
Who reported it?		What date did they report it?	
What kind of incident are you reporting? <input type="checkbox"/> Injury <input type="checkbox"/> Near miss <input type="checkbox"/> Property damage <input type="checkbox"/> Environmental damage			
Who completed this form?		Names of people who saw what happened?	
Describe what happened:		What did you do immediately to make the scene safe?	
What was the risk source that caused this event? (mechanism)			
<input type="checkbox"/> Asbestos	<input type="checkbox"/> Biological hazard	<input type="checkbox"/> Electricity	<input type="checkbox"/> Hazardous substances
<input type="checkbox"/> Machinery (fixed)	<input type="checkbox"/> Machinery (hand held)	<input type="checkbox"/> Housekeeping	<input type="checkbox"/> Mobile plant & equipment
<input type="checkbox"/> Slips, trips, and falls	<input type="checkbox"/> Work at height	<input type="checkbox"/> Violence/security	<input type="checkbox"/> Work environment (noise, dust, sun, etc)
<input type="checkbox"/> Fire	<input type="checkbox"/> Vehicles	<input type="checkbox"/> Other:	
How bad could the incident have been? (most credible serious outcome/consequence) <input type="checkbox"/> Routine <input type="checkbox"/> Minor <input type="checkbox"/> Moderate <input type="checkbox"/> Major <input type="checkbox"/> Severe			
How likely is it that it will happen again? <input type="checkbox"/> Rare <input type="checkbox"/> Unlikely <input type="checkbox"/> Possible <input type="checkbox"/> Likely <input type="checkbox"/> Almost certain			

Injured person's details

Only complete this section if there was an injured person

Injured person's name:		Injured person's job title:	
Their date of birth:		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor <input type="checkbox"/> Volunteer <input type="checkbox"/> Visitor	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans/other		Length of employment:	
Injured person's manager:		Work time: <input type="checkbox"/> Day <input type="checkbox"/> Afternoon <input type="checkbox"/> Night	
Injury outcome	<input type="checkbox"/> First aid	<input type="checkbox"/> Medical treatment	<input type="checkbox"/> Lost time (off work)
			<input type="checkbox"/> Notifiable injury/illness*
			<input type="checkbox"/> Fatal
<i>*If the event is notifiable to WorkSafe, preserve the scene of the event and call WorkSafe as soon as possible.</i>			
What body part was injured? <input type="checkbox"/> Head <input type="checkbox"/> Eyes <input type="checkbox"/> Neck/shoulder <input type="checkbox"/> Arm/wrist <input type="checkbox"/> Hands/fingers <input type="checkbox"/> Upper back <input type="checkbox"/> Lower back <input type="checkbox"/> Torso/internal organs <input type="checkbox"/> Leg <input type="checkbox"/> Foot/toes <input type="checkbox"/> Multiple locations			
What was the type of injury? <input type="checkbox"/> Sprain/strain <input type="checkbox"/> Scratch/small abrasion <input type="checkbox"/> Laceration/cut <input type="checkbox"/> Bruise <input type="checkbox"/> Crush <input type="checkbox"/> Fracture <input type="checkbox"/> Amputation <input type="checkbox"/> Burn/scald <input type="checkbox"/> Dislocation <input type="checkbox"/> Internal injury <input type="checkbox"/> Foreign body <input type="checkbox"/> Poisoning/toxic effects <input type="checkbox"/> Skin/dermatitis <input type="checkbox"/> Concussion/head injury <input type="checkbox"/> Mental illness <input type="checkbox"/> Respiratory illness <input type="checkbox"/> Occupational illness (e.g. cancer, asbestosis, silicosis)			