Apprenticeships r Us Incident and Investigation Report

Details of person injured or involved

Full Name:	Date of Event: ' Time of Event:
Occupation:	Investigating Manager:
Date Of Birth:	Host Employer:
Contact Number:	Workshop Foreman or Service Manager:

Please forward all incident reports to Kurt Willis by either Fax (02 9687 3069) or Email to kwillis@apprus.com.au within 24 hours of the event.

Injury Details

Description of Injury/medical condition:
Is this an aggravation of a previous injury or condition? I Yes I No I Not Known
Location/Address details of where the injury/ event occurred:

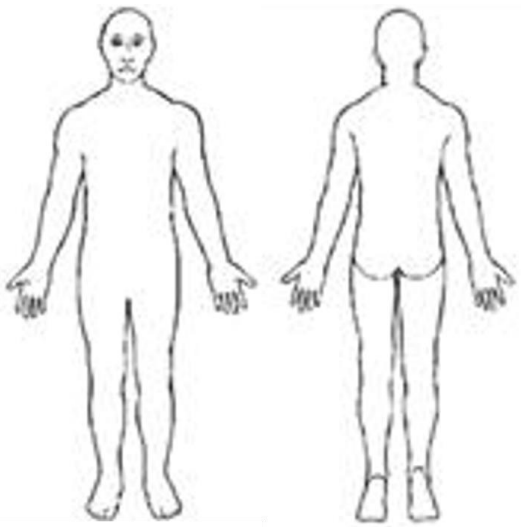
Medical treatment obtained: (please circle)
Nil j First Aid I Hospital* ! Medical Centre* I other I
First Aid Treatment provided by:
* Medical Treatment provided by Medical Centre or Hospital: (request a Certificate of Capacity whilst there)
Outcome for injured person:
Time lost from work: Days Hours

RISK CONTROLS: What action has or will be taken to prevent re-occurrence?

Investigative Questions	YES	NO
Was this HAZARD previously detected?		
If yes, is it recorded in the HAZARD Register?		
Were there any CONTROLS in place to prevent this incident?		
If yes, what are they?		
Were there any other contributing factors?		
What are they?		

Apprenticeships Plus Incident and Investigation Report

Observations:



Type of Injury

U Amputation	U Head Injury
Q Bruise	0 Heat Stress/Exhaustion
Q Bum/s	0 Internal Injury
0 Cut/Laceration	0 Poisoning/Toxic Effects from substance
0 Dislocation	Q Sprain / Strain
0 Foreign Body	0 Other (Please specify below)
Q Fracture Graze/Scratch / Abrasion	O .....

Bodily Location of Injury - Indicate left or right as appropriate L or R next to the body part

Head/ Face	Trunk / Torso	Upper Limbs	Lower Limbs
U Head	0 Neck	Q Shoulder	Q Hip
0 Face	0 Upper Back	0 Upper Arm	Q Thigh
0 Eyes	0 Lower Back	Q Elbow	0 Knee
Q Ear	O Chest	Q Forearm	Q Calf
0 Nose	0 Abdomen	0 Wrist	Q Ankle
O Mouth	0 Groin/ Pelvic Region	0 Hands. Fingers & Thumb	Q Foot
Q Head (Multiple)	0 Trunk (Multiple)	0 Upper Limb (Multiple)	0 Toes
			0 Lower limb (multiple)

Type of Disease

U Allergic Reaction	U Infectious/ Infection
0 Dermatitis / Eczema	Q Parasitic
O Circulatory System	O Loss of Consciousness / Fainting
0 Muscles, Tendons and Soft Tissue	0 Seizure
0 Eye Disorders	O Psychological
0 Hearing Loss	0 Respiratory Irritation
0 Hernia	Q Other (please specify below)
	0 .....

Where there an witnesses? Yes No

Contact Name:

Information About Personal Protective equipment (PPE):

Should PPE have been worn during the t ask being undertaken at the time of the incident? YES or NO

Was it available? YES or NO

Was it being worn/ used? YES or NO

Type of PPE required :

Any other observation/ comments from Supervisor or Manager:

Investigator Name:	Workshop Foreman or Supervisor Name:
Investigator Signature:	Workshop Foreman or Supervisor Signature:
Date:	Date: