



Apprenticeships Are 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 Business:	
Contact Number:	Workshop Foreman or Service Manager:	

Please forward all incident reports to Marlene Hatem by Email to hr@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?	Yes	No	Not Known
Location/Address details of where the injury/ event occurred:			

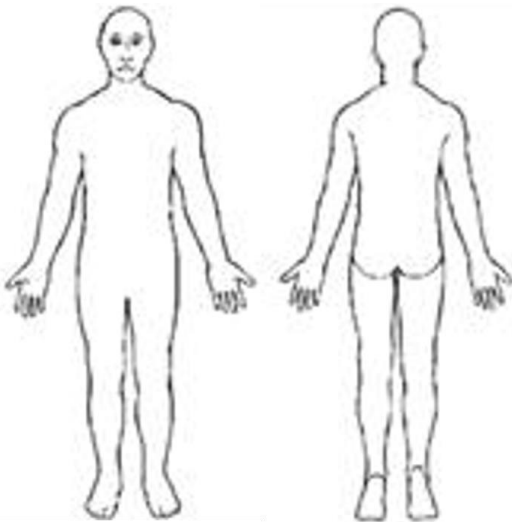
Medical treatment obtained: (please circle)			
Nil	First Aid	Hospital*	Medical Centre*
other			
First Aid Treatment provided by:			
* Medical Treatment provided by Medical Centre or Hospital: (request a Certificate of Capacity whilst there)			
Outcome for injured person:			
Time lost from work:	Days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

- | | |
|---|---|
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Head Injury |
| <input checked="" type="checkbox"/> Bruise | <input type="checkbox"/> Heat Stress/Exhaustion |
| <input checked="" type="checkbox"/> Bum/s | <input type="checkbox"/> Internal Injury |
| <input type="checkbox"/> Cut/Laceration | <input type="checkbox"/> Poisoning/Toxic Effects from substance |
| <input type="checkbox"/> Dislocation | <input checked="" type="checkbox"/> Sprain / Strain |
| <input type="checkbox"/> Foreign Body | <input type="checkbox"/> Other (Please specify below) |
| <input checked="" type="checkbox"/> Fracture | <input type="checkbox"/> |
| <input type="checkbox"/> Graze/Scratch / Abrasion | |

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
<input type="checkbox"/> Head	<input type="checkbox"/> Neck	<input checked="" type="checkbox"/> Shoulder	<input checked="" type="checkbox"/> Hip
<input type="checkbox"/> Face	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Upper Arm	<input checked="" type="checkbox"/> Thigh
<input type="checkbox"/> Eyes	<input type="checkbox"/> Lower Back	<input checked="" type="checkbox"/> Elbow	<input type="checkbox"/> Knee
<input checked="" type="checkbox"/> Ear	<input type="checkbox"/> Chest	<input checked="" type="checkbox"/> Forearm	<input checked="" type="checkbox"/> Calf
<input type="checkbox"/> Nose	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Wrist	<input checked="" type="checkbox"/> Ankle
<input type="checkbox"/> Mouth	<input type="checkbox"/> Groin/ Pelvic Region	<input type="checkbox"/> Hands, Fingers & Thumb	<input checked="" type="checkbox"/> Foot
<input checked="" type="checkbox"/> Head (Multiple)	<input type="checkbox"/> Trunk (Multiple)	<input type="checkbox"/> Upper Limb (Multiple)	<input type="checkbox"/> Toes
			<input type="checkbox"/> Lower limb (multiple)

Type of Disease

- | | |
|---|--|
| <input type="checkbox"/> Allergic Reaction | <input type="checkbox"/> Infectious/ Infection |
| <input type="checkbox"/> Dermatitis / Eczema | <input checked="" type="checkbox"/> Parasitic |
| <input type="checkbox"/> Circulatory System | <input type="checkbox"/> Loss of Consciousness / Fainting |
| <input type="checkbox"/> Muscles, Tendons and Soft Tissue | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Eye Disorders | <input type="checkbox"/> Psychological |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Respiratory Irritation |
| <input type="checkbox"/> Hernia | <input checked="" type="checkbox"/> Other (please specify below) |
| | <input type="checkbox"/> |

Were there any witnesses? **Yes** **No**

Contact Name:

Information About Personal Protective equipment (PPE):

Should PPE have been worn during the task 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 (If no, why?)

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: