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Information

Document No.

Audit Title

Client / Site

Conducted on



Prepared by

Location



Personnel

This form must be completed for an incident involving injury/illness or reporting a workplace hazard or near miss involving property and/or environmental damage. Incidents involving actual or potential significant injury/illness must be reported immediately to management.

Person Completing the Form

First Name

Last Name

Contact Phone Number

Position/Job Title

Incident/Injury/Hazard/Near Miss

Description

Incident Hazard Injury Near Miss

Date and Time of Incident



Date and Time Reported



Location Details

Incident Type

What type of Incident are you Reporting?

- Injury/Illness Hazard Near Miss Vehicle
-

Was there any 3rd Party Damage, Environmental or Vehicle/Plant Damage?

- 3rd Party Property Damage Environmental Damage

- Vehicle/Plant Damage
-

Description of damage caused

Injured/Ill Person Details

Family Name

Given Name(s)

Date of Birth

Gender

Male Female

Address

Contact Number

Occupation

Supervisors Name

Contact Number

Employment Status

Permanent Fixed Term Casual Contractor Part-Time Visitor Other

Incident Description

Explain what Happened

Injury/Illness Details

Injury Type

- Lost Time Injury
- Modified Duties Injury
- Light Duties Injury

Date and Time Duties Modified



Treatment Type

- Medical Treatment
- Hospital
- First Aid
- Ambulance Called
- Intend to Seek Medical Treatment
- Work Cover Medical Certificate Issued
- No Treatment Required

Description of Treatment Provided

Treatment Provided By

Contact Number

Diagnosis of Injury/Illness

Task being undertaken at time of injury/illness

What part of the body was injured

Witness Details (if Applicable)

Name

Address

Phone Number

Add signature



Date



WHAT HAPPENED? (Immediate Cause)

Describe what happened

Possible Contributing Factors (select all that apply)

Lack of Knowledge

- Yes No N/A
-

Employee Placement

Yes No N/A

Not Enforcing Safe Work Practices

Yes No N/A

Engineering

Yes No N/A

Inadequate Personal Protective Equipment (PPE)

Yes No N/A

Inadequate Maintenance Programs

Yes No N/A

Purchasing Inadequate/Inferior Equipment

Yes No N/A

Inadequate Feedback Systems

Yes No N/A

Unsafe Work Method

Yes No N/A

Recommended Corrective Action Plan

Basic Cause

Corrective Action Plan

Person Responsible

Target Completion Date



Risk Assessment

Consequences: Consider what did or Could have happened

- 1 2 3 4
-

1=Death and Extensive Injuries, 2=Medical Treatment, 3=First Aid Treatment, 4=No Treatment

Likelihood: How likely could this happen again

- A B C D
-

A=Could Occur in Most Instances, B=Could Occur at Some Time, C=Could Occur, but only Rarely, D=May Occur, but Probably never will

Risk Score

- High Medium Low
-

Applicants Details

Name

Position

Contact Number

Date Recorded



Signature



Managers Details

Name

Position

Contact Number

Date Recorded



Signature

Reporting

LTI:

 Yes No N/A

MTI:

 Yes No N/A

Medical Certificate Required

 Yes No N/A

Workcover Notified

 Yes No N/A

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