



INCIDENT REPORT FORM

INSURED NAME: _____ TELEPHONE NO.: _____

DATE REPORTED: _____ TIME REPORTED: _____

EXACT LOCATION: _____

FAX TO PROCLAIM

1300 858 329

DATE OF INCIDENT: _____ TIME OF INCIDENT: _____ DAY OF WEEK: _____

INCIDENT REPORT COMPLETED BY _____ INCIDENT REPORTED TO: _____

TIME INCIDENT LOCATION INSPECTED: _____ INSPECTED BY: _____

PART 1: INJURED PERSON/PROPERTY OWNER DETAILS

NAME: _____
(Surname) (Given Names)

ADDRESS: _____

TELEPHONE NO: (Home) _____ (Business) _____ (Mobile) _____

DATE OF BIRTH: _____ (approx or guess if unknown) MALE FEMALE

WALKING STICK GLASSES CARRYING GOODS OTHER IMPAIRMENTS

PART 2: WITNESS DETAILS *

* Eyewitnesses witnessed the incident; circumstantial witnesses witnessed the events leading up to or following the incident. Additional witnesses' details should be provided on attachment.

ATTACH STATEMENTS FOR ADDITIONAL COMMENTS

NAME OF WITNESS TO ACCIDENT: _____
(Surname) (Given Names)

ADDRESS OF WITNESS: _____

TELEPHONE NO: (Home) _____ (Business) _____ (Mobile) _____

TYPE OF WITNESS: EYE WITNESS CIRCUMSTANTIAL WITNESS

RELATIONSHIP TO INJURED PERSON: _____

(If more than one witness, please provide details) _____

IF ANOTHER PARTY RESPONSIBLE, PLEASE PROVIDE DETAILS: _____

PART 3: PERSONAL INJURY DETAILS

PART OF BODY INJURED (Place tick in appropriate box)

Head & Neck <input type="checkbox"/>	Hip <input type="checkbox"/>	Hands/ Fingers <input type="checkbox"/>
Eyes or Face <input type="checkbox"/>	Shoulder <input type="checkbox"/>	Knee <input type="checkbox"/>
Back & Trunk <input type="checkbox"/>	Arms / Wrists <input type="checkbox"/>	Feet and toes <input type="checkbox"/>

If Other, or multiple, please describe: _____

NATURE OF INJURY (Place tick in appropriate box)

Multiple <input type="checkbox"/>	Minor Bruise - Not Disabling <input type="checkbox"/>	Concussion/Unconscious (Serious) <input type="checkbox"/>
Fracture <input type="checkbox"/>	Major Bruising - Disabling <input type="checkbox"/>	Burns/Scalds – requiring medical attention <input type="checkbox"/>
Sprain <input type="checkbox"/>	Minor Cut/Laceration - No Stitches <input type="checkbox"/>	Superficial <input type="checkbox"/>
Dislocation <input type="checkbox"/>	Cut/Laceration requiring Stitches <input type="checkbox"/>	No Apparent Injury <input type="checkbox"/>
Ligament Damage <input type="checkbox"/>	Minor Concussion <input type="checkbox"/>	

If Other, describe: _____

DESCRIPTION OF and SEQUENCE OF EVENTS LEADING UP TO THE INCIDENT (as described by injured party)

DESCRIPTION OF INCIDENT (by you or independent witness)

WAS INJURED PERSON TAKEN TO: TREATMENT BY FIRST AIDER DOCTOR/HOSPITAL AMBULANCE

NAME OF FIRST AIDER/ PERSON ATTENDING: _____ TELEPHONE NO: _____

OTHER (Please describe): _____

IF THIRD PARTY/CONTRACTOR AT FAULT: THIRD PARTY/CONTRACTOR'S NAME: _____

THIRD PARTY/CONTRACTOR'S INSURANCE DETAILS _____

PART 4: PROPERTY DAMAGE (complete if there is property damage)

ITEM DAMAGED: _____

DETAILS: _____

IF VIEWED AND BY WHOM: _____

PHOTOS TAKEN AND BY WHOM: _____

PART 5: LOCATION OF INCIDENT (Please tick in appropriate box)

Car Park	<input type="checkbox"/>	Entrance/Exit	<input type="checkbox"/>	Stairs	<input type="checkbox"/>
Car Park Ramps	<input type="checkbox"/>	Office Areas	<input type="checkbox"/>	Escalators	<input type="checkbox"/>
Bar	<input type="checkbox"/>	Internal Ramp	<input type="checkbox"/>	Elevators	<input type="checkbox"/>
Toilet Areas	<input type="checkbox"/>	Children's Play Area	<input type="checkbox"/>	Restaurants	<input type="checkbox"/>
Food areas	<input type="checkbox"/>	Balcony	<input type="checkbox"/>	Gaming areas	<input type="checkbox"/>

If Other, describe: _____

PART 6: TYPE OF INCIDENT (Please tick in appropriate box)

Slip and Fall of Person: Cause

Chips	<input type="checkbox"/>	Lack of Barrier	<input type="checkbox"/>	Uneven Floor	<input type="checkbox"/>
Ice Cream	<input type="checkbox"/>	Rainwater on floor	<input type="checkbox"/>	Tripped over Object	<input type="checkbox"/>
Beverage	<input type="checkbox"/>	Barrier/Signs	<input type="checkbox"/>	Steps/Stairs	<input type="checkbox"/>
Floor Slippery (Surface)	<input type="checkbox"/>	Vegetable/Fruit items	<input type="checkbox"/>	Car Park Stops/Bollards	<input type="checkbox"/>
Inadequate Lighting	<input type="checkbox"/>	Other Food	<input type="checkbox"/>	No apparent Reason	<input type="checkbox"/>
Person running	<input type="checkbox"/>	Vomit	<input type="checkbox"/>		

If Other, describe: _____

OR Caught in:

Door	<input type="checkbox"/>	Escalator/Elevator	<input type="checkbox"/>
Machinery	<input type="checkbox"/>	Other	<input type="checkbox"/>

If Other, describe: _____

Stepping on or Striking Against:

Display Stands	<input type="checkbox"/>	Escalator/Elevator	<input type="checkbox"/>	Other	<input type="checkbox"/>
Sharp Edges/Protruding Objects	<input type="checkbox"/>	Doors	<input type="checkbox"/>		

If Other, describe: _____

Other

Falling Objects If Falling objects, please describe: _____

Water Damage

Type of surface

Marble	<input type="checkbox"/>	Tile	<input type="checkbox"/>	Carpet	<input type="checkbox"/>	Speed hump	<input type="checkbox"/>
Terrazzo	<input type="checkbox"/>	Timber	<input type="checkbox"/>	Bitumen	<input type="checkbox"/>	Dirt/grass/garden	<input type="checkbox"/>
Slate	<input type="checkbox"/>	Vinyl	<input type="checkbox"/>	Concrete	<input type="checkbox"/>	Other	<input type="checkbox"/>

If Other, describe: _____

WAS INJURED PERSON Reasonable Upset Aggressive Add relevant comments

CLEANER ON DUTY: _____ CLEANING SUPERVISOR: _____

TIME LOCATION LAST INSPECTED: _____ TIME LAST CLEANED: _____

PLEASE ATTACH WRITTEN STATEMENT FROM CLEANER (If appropriate)

RECORD OF INCIDENT Video/closed circuit Photo None