Seasonal Solutions Cooperative Ltd

INCIDENT/ACCIDENT REPORT FORM

INJURED PERSON	INCIDENT
Name:	**Date:**
Date of Birth:	**Location:**
Address:	**Time:**

Tick Appropriate boxes:		
Male ☐ Female ☐	**Fulltime ☐ Casual ☐ RSE ☐ Contractor ☐ Visitor ☐**	**Length of employment:**

Please circle:

Near Miss / Serious harm / Minor Harm **First aid / Doctor / Hospital** **Return to work / Light duties / Time off required (medical certificate)**

INCIDENT DETAILS	
What happened?	**Was the person trained for the task they were doing?**
	Was a significant risk involved? Yes / no **If yes:**
Where and when did it happen?	**What is the nature of the person's injury?**
Why did it happened?	
What can be done to reduce the chance of a repeat incident:	

FORM COMPLETED BY		
Name:	**Sign:**	**Date:**