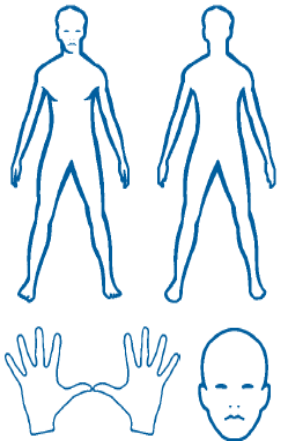
Wanganui Competitions Society Inc. - Accident/Incident/Early Reporting Form

Work Area / Department	Time of Incident hh:mm pm / am Time started Shift hh:mm pm / am	Incident Date dd/mm/yyyy Date of Report dd/mm/yyyy	Injured Employee Name : Enter here Date of birth dd/mm/yyyy:
First Aider (write name clearly)	Witness	**TREATMENT** (Tick appropriate box) Nil ☐ First Aid ☐ Doctor ☐ Hospital ☐	

STATUS (tick appropriate box) Permanent ☐ Fixed Term ☐ Contractor ☐ Other ☐ (please state)

Discomfort/Injury Details – Body Part



Discomfort/Injury Type (tick)

- ☐ Aches/pain (gradual)
- ☐ Aches/pain (sudden)
- ☐ Amputation
- ☐ Broken bone
- ☐ Bruising incl. crushing
- ☐ Burn/scald
- ☐ Chemical reaction
- ☐ Choking/suffocation
- ☐ Concussion/brain injury
- ☐ Cut (infected)
- ☐ Cut (not infected)
- ☐ Dental injury
- ☐ Dermatitis
- ☐ Dislocation
- ☐ Fatal
- ☐ Foreign body
- ☐ Eye ☐ Nose ☐ Ear
- ☐ Inhalation disease (asbestos / lead)
- ☐ Hearing loss (noise induced)
- ☐ Poisoning
- ☐ Strain/sprain
- ☐ Other
- ☐ Multiple injuries

Severity:

1. Sever pain
2. Pain
3. Mild pain
4. Discomfort

Severity Scale Enter here

Duration

A. Discomfort/Pain is always present to some degree
B. Discomfort/pain stays after work but improves after a night's rest
C. Only at work
D. Occasional

Duration Scale Enter here

Description of Accident / Incident: (please describe your interpretation of events)
Enter here

Information for Discomfort for Early Reporting:

- When did you first notice discomfort / pain?
- Is it getting worse, better or staying the same?
- Have you had this discomfort/pain before?
- What are you doing to help relieve the discomfort/pain?
- Is there anything else you feel we should know? (note on reverse)

Root Cause(s) of Incident	Initial Control/Corrective Action Suggested Action/s	Person Responsible for completing	Date Completed	Review Completed

Is Further Investigation Required? Yes ☐ No ☐ (If no, please give reason):

Final Classification: Early Discomfort Incident (EDI) ☐ / Near Miss Incident (NMI) ☐ / First Aid Incident (FAI) Medical Treatment Incident (MTI) ☐ / Lost Time Incident (LTI) ☐

Department Manager Sign off: _____ Date: _____
Initiator Sign off: _____ Date: _____

Other Sign off eg Health & Safety Committee:
Yes ☐ No ☐ _____ Date: _____