



Accident/Incident Report (AIR)

When to use this form

This form is to be used to report all work related accidents/incidents or circumstances that did or could have resulted in an accident or incident including:

- **injury/illness to a person (includes third parties)**
- **equipment/plant failure**
- **property damage**
- **harm to environment**
- **theft or security issue**

Instructions for Person Injured or exposed to an accident/incident (or their representative)

1. Complete **Parts A, B, C, and D** (Supervisor/Manager, or persons representative, to complete if affected person unable).
2. Save the completed form to your computer (or print for hardcopy), then email or forward the completed AIR to your supervisor/manager.
3. Retain a copy of the AIR for your own records.

Instructions for Supervisor/Manager

1. Ensure Parts A, B, C, and D have been completed (Supervisor/Manager, or persons representative, to complete if affected person unable).
2. Complete **Part E**.
3. Forward to your Agency's Injury Prevention and Management (IP&M) Team.
4. Return a copy of the completed AIR to the person involved in the accident/incident.
5. If compensation is to be claimed, ensure a copy of this AIR is included with the Worker's Compensation Claim Kit.
6. Reporting Requirements - There is a requirement to **report all incidents within 48 hours**. Serious Events must also be reported to Office of Regulatory Services (ORS) WorkCover (see below)

Serious Events - Guide for Supervisors/Managers on reporting

Type	Notify	When to Act
Death	1,2,3	IMMEDIATELY (followed by WRITTEN notice to ORS WorkCover within 48 hours)
Serious Events including Dangerous Occurrence (potential to cause serious injury/illness/ damage)	1,2,3	Within 48 hours or as soon as possible after the event within ACT Government agencies To ORS WorkCover no later than 7 days after the event
Injury/ Illness (7 days or more off work)	1,2,3	
Third Party Incident (injury/illness or death)	1,2,3,4	

Notification key:

1. ORS **WorkCover** Ph: 620 50200 Fax: 620 50336
2. Your Agency **Chief Executive**
3. Your Agency **Injury Prevention and Management** team (Small agencies **SSHS** Ph: 620 54519)
4. **ACTIA** for third party incidents Ph: 620 70184

Note. Your IP&M team will forward the AIR to the Chief Minister's Department (CMD) and to Shared Services Health and Safety (SSHS) for SSHS clients including: TAMS, DET, DHCS, DT, JACS, CFC, CIT, LaPS, LDA, ACTPLA, CMD, DECCEW

Compensation Claims

Completion of this form is not an admission of liability nor is it a claim for compensation.

Information regarding workers' compensation can be obtained from your IP&M Team or from Comcare Australia on 1300 366 979.

Privacy Notice

The information in this form will only be disclosed to those for whom it was collected.

The information in this form is collected to comply with the ACT Government's responsibilities for recording workplace accidents/incidents and in accordance with the following legislation:

- *ACT Work Safety Act 2008* and Work Safety Regulation 2009
- The *Privacy Act 1988 (Cwth)*. The Privacy Act entitles you to check the record processed from the information you have provided and to correct any inaccuracies.

Enquiries regarding the collection of this data should be directed to CMD, Workplace Injury Performance Team Ph: 620 50338.

Part A - Personal details of person(s) involved in the accident / incident

1. Family Name/Surname Given Name/s

Date of Birth DD/MM/YYYY Male Female

2. Status of person involved

ACT Govt Employee**AGS/ID No:**

ACT Legislative Assembly Non Members Staff

Contractor/Agency Worker

Student (eg. CIT). Provide Student id no.

Visiting Medical Officer

Volunteer Emergency Worker

Other Third Party. Provide details:

3. Your Agency/Employer

Agency

Branch/Section

Part B - Accident/Incident Details

4. Date and time of incident

Date DD/MM/YYYY Time eg 16:30 which is 4:30pm

5. Details of Witnesses

Witness 1 Full Name

Contact Number Mobile

Witness 2 Full Name

Contact Number Mobile

6. Where did the accident/incident occur

At the usual work place At recess (eg. Lunch)

When travelling as part of the job When travelling to/from work

Working away from usual workplace (e.g. in the field)

Other. Provide details:

7. What was the exact location of the accident/incident? (e.g. Science lab2, Holder Oval)

8. What task was being performed at the time of the accident/incident?

(eg Teaching Year 10 science, Mowing Grass)

9. Was the accident/incident caused or related to the above task?

YES NO

10. Date and Time Agency became aware of the accident/incident?

Date DD/MM/YYYY Time eg 16:30 which is 4:30pm

11. Have you received specific training in the task being performed at the time of the accident/incident?

YES NO

If **YES** what type?

Induction Vocational/ Job Specific Task Specific
Other. Provide details:

12. How much experience have you had in doing the tasks you were performing at the time of the accident/incident?

YEARS MONTHS Not Applicable

13. Was the accident/incident caused by a violent or abusive act?

YES NO

If **NO**, go to question 16. If **YES**, then

14. Who or what caused the violent abuse?

Client Another employee Student

Patient Other. Provide details:

15. What form of violence or abuse took place?

Verbal Physical Other. Provide details:

16. Describe how the accident/incident happened.

Please include the name of any particular chemical, product or equipment involved in the accident/incident

Note: Click here if you require more space.

17. To what extent did the accident/incident affect you?

No injury or illness, it was a hazardous situation -

If **NO injury or illness**, go to question 22

Minor injury or illness - no time was lost as a result

Less than one day of lost work

One day or more of lost work

Part C - Injury/Illness Details (Complete if an injury or illness occurred as a result of the accident/incident)

18. Which body parts were affected by the accident/incident?

(Tick all those affected)

Eye	Ear	Mouth	Neck	Shoulder
Arm	Elbow	Wrist	Hand	Finger/Thumb
Back	Knee	Hip/Buttocks	Leg	Ankle
Foot	Toes	Chest/Trunk	Respiratory System	
Internal Organs (other than above)			Face (other than above)	
Head (other than above)			Psychological System	
Other. Provide details:				

19. Describe the injury/illness and how it affects you.

(eg bruised right ankle, unable to bear weight) **Note: Click here if you require more space.**

Part C - Injury/Illness Details (Continued)

20. What treatment was given?

None	Hospital Admission
On site health centre	First aid or alternative treatment
Doctor/Casualty/Physiotherapy	Paramedic/Ambulance treatment
Employee Assistance Program (EAP)	Other. Provide details:

21. Was personal protective equipment/clothing worn at the time of the injury/illness? *(Tick all that are relevant)*

None	Footwear	Eye Protection
Ear Protection	Respiratory	Helmet/Head Protection
Hand Protection	Harness or Restraint	Other. Provide details:

22. What was your employment grade or level at the time of the accident/incident?

23. What was your job title or description at the time of the accident/incident?

24. What was the work status at the time of the accident/incident?

Permanent Full-Time	Casual Full-Time
Permanent Part-time	Casual Part-Time
Temporary Full-Time	Temporary Part-Time
Other. Provide details:	

25. How many hours do you normally work each week?

36 Hours, 45 Minutes 38 Hours Other. Provide details:

26. What time did you start work on the day of the accident/incident?
am/pm

27. Are you a shift worker?

YES NO If **YES** provide details:

Part D - Person completing this form.

Name Position Level

Contact Number Mobile

Date Signature

DD/MM/YYYY

When creating a new electronic signature, ensure that you choose the 1024-bit RSA encryption. See the factsheet on the Shared Services website for more information.

Note: for injured party or representative.

Once you have completed and saved your section of this form to your computer, email or forward it to your Supervisor/Manager to complete.

Keep a copy for your own records.

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Part E - SUPERVISOR/MANAGER TO COMPLETE

28. Has the designated Work Safety Representative (WSR) been advised of the accident/incident?

YES NO

29. Is the accident/incident a 'Serious Event' notifiable to ORS Workcover?

If **YES** continue If **NO** go to question 32

YES NO

30. Is ORS WorkCover going to conduct an investigation?

YES NO ORS WorkCover to advise

31. What date was ORS WorkCover notified by phone (6205 0200) or facsimile (6205 0336)?

Date DD/MM/YYYY

32. What date was your agency IPM team/SSHS informed?

Date DD/MM/YYYY

33. Who will conduct formal internal investigation?

Manager/Supervisor SSHS Internal Investigator

Corrective and Preventative Measures

34. What short term corrective action/s have been taken?

35. What medium/long term corrective action/s have been taken?

PREVENTATIVE ACTIONS	PROPOSED	COMPLETED
Change to induction training		
Change to ongoing training		
Equipment/machinery modification		
Equipment/machinery maintenance		
Change to work procedures		
Change to work environment		
Other job redesign		
Other preventative action		
Prevention action unnecessary		

36. Provide your comments/recommendations on the preventative actions selected:

Name of Supervisor/Manager completing this form

Name Position Level

Date Contact Number Mobile

Branch/Section Signature

Note: for Supervisor/Manager. Sign and save a copy of this form for your records and forward to the appropriate parties, including the injured/ill party, IncidentReporting@act.gov.au, your agency IPM Team/for small agencies to SharedServicesSafety@act.gov.au.

For further information, refer to instructions on Page 1 of this form.

SSHS use Only - Additional recommendations/comments (if required)

SSHS Investigation Required? YES NO

SSHS Advisor Phone Date

CMD Workplace Injury Performance use Only

Agency Code	Breakdown
Agency	Mechanism
Nature	Body

16. (Cont.) Describe how the accident/incident happened.

Please include the name of any particular chemical, product or equipment involved in the accident/incident

Note: This area provided only if you require more space than that provided at Q.16.

19. (Cont.) Describe the injury/illness and how it affects you.

(eg bruised right ankle, unable to bear weight)

Note: This area provided only if you require more space than that provided at Q.19.