

4.05b Incident Report – Student/Visitor

11 August 2010

To be completed within 24 hours of incident

Part A: To be completed by the Injured Student/Visitor

Details of Injured/Ill Student/Visitor

Surname: _____ Given Names: _____

Home Address Street: _____

City: _____ State: _____ P/Code: _____

Phone No. Work: _____ Home: _____ Mobile: _____

Student Visitor : Employer (if any): _____

Injury/Illness Details

Type of injury (please tick where applicable)

- | | | |
|---|--|--|
| <input type="checkbox"/> Fracture/Dislocation | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Damage to artificial aids |
| <input type="checkbox"/> Burn/Scald | <input type="checkbox"/> Contusion/Crush | <input type="checkbox"/> Bite/Sting |
| <input type="checkbox"/> Cut/Abrasion (First-aid only) | <input type="checkbox"/> Poison | <input type="checkbox"/> Strain/Sprain |
| <input type="checkbox"/> Open Wound (Medical Treatment) | <input type="checkbox"/> Amputation | <input type="checkbox"/> Other _____ |

Bodily location of injury/illness: _____

First-aid/Medical Treatment

If any First-aid and/or Medical treatment was required please state name and phone number of First-Aid /Medical attendant:

Name: _____ Phone Number: _____

Details of Incident

Date of Incident: ____ / ____ / ____ Time of Incident: _____ am/pm

Date incident reported: ____ / ____ / ____

Location of incident: _____

Mechanism of the injury/illness/dangerous occurrence. (please tick where applicable)

- | | |
|--|---|
| <input type="checkbox"/> Slip, trip or fall | <input type="checkbox"/> Body stress (exertion to muscles, tendons, ligaments & bone) |
| <input type="checkbox"/> Mental Stress | <input type="checkbox"/> Chemical or other substance exposure |
| <input type="checkbox"/> Noise or Vibration | <input type="checkbox"/> Hitting objects with part of the body |
| <input type="checkbox"/> Struck by a moving object | <input type="checkbox"/> Biological exposure (germs, viruses & bacteria) |

Brief description of incident: _____

If any witnesses please state name and phone number

1. Name: _____ Phone Number: _____

2. Name: _____ Phone Number: _____

3. Name: _____ Phone Number: _____

Any further comments: _____

Declaration

To be completed by the injured/ill student/visitor:

I _____ hereby declare that the information provided in the foregoing statement is true and correct.

Signature: _____ Date: ____ / ____ / _____

Name: _____

Please Print

Please send to: **The Occupational Health and Safety Unit**
Level 3, T.C. Lamble Building
The University of New England
Armidale NSW 2351
Email: ohs@une.edu.au

Part B: To be completed by Occupational Health and Safety Unit

Action taken to prevent the incident from occurring in the future: _____

Signature: _____ Date: ____ / ____ / _____

Name: _____

TRIM Document No.: D07/18211