|  |  |  |  |
| --- | --- | --- | --- |
| **Family name:** |  | **First name:** |  |
| **Position:** |  | **Service name:** |  |

1. **Name of person reporting the incident**

**2. Details of any person Injured: (if different from the person reporting)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Family name:** |  | **First Name:** |  |
| **Position:** |  | **Service name:** |  |

**3. Incident Details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date of incident:** |  | | **Time of Incident:** | am/pm |
|  | | | | |
| Describe what happened, how the injury was sustained? | | | | |
|  | | | | |
| **What is the injury?** | | | | |
|  | | | | |
| **The location at the time of injury?** | | | | |
|  | | | | |
| If equipment, materials or the environment was involved in the incident / injury, please name/describe the equipment, material or environment | | | | |
|  | | | | |
| **Treatment Required: (tick applicable box)** | | | | |
| 🞏 None 🞏 First aid 🞏 Doctor 🞏 Hospital  🞏 Other ………………………………………………………………………………………………………………….. | | | | |
| **Was the incident reported to the Nominated Supervisor or Superior in Day to Day charge at the time of the incident Y / N** | | | | |
| Did the injured worker return to work following the injury? | | Yes / No (Please circle your response) | | |
| *If yes, please provide details:* | | | | |

**4. Witnesses:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Were there any witnesses to the incident / injury?** | | | | Yes / No (Please circle your response) |
| *If yes, please list the witnesses’ full names as well as a contact number for each.* | | | | |
| *Name:* |  | *Name:* |  | |
| *Name:* |  | *Name:* |  | |

**5. Declaration:**

|  |  |  |  |
| --- | --- | --- | --- |
| **I confirm that the information given in this form is true, complete and accurate:** | | | |
| **Name:** |  | | |
| **Signature:** |  | **Date:** |  |

**6. Initial Investigation and Prevention Investigation (to be completed by the Nominated Supervisor)**

Action taken/recommended to reduce risk or prevent reoccurrence.

Consider the contributing factors identified prior (i) equipment (ii) materials (iii) environment, physical layout (iv) people, knowledge, training, behaviour, culture, supervision, methods, procedures.

|  |  |  |  |
| --- | --- | --- | --- |
| **Has an investigation been conducted into the incident at the service?** | | Yes / No (Please circle your response) | |
| **What, if any, action/s have been undertaken to ensure the incident does not happen again?** | | | |
|  | | | |
| **If equipment, material or environment was identified as contributing to the injury please upload a photo and details to the IMS Compliance checklist.** | | | |
| **Does this require any further follow up from ECKA management?** | **YES** | | **NO** |

**7. Employer Confirmation (CEO)**

|  |  |  |  |
| --- | --- | --- | --- |
| I …………………………………………………………….. (print name), of | | | |
| Eureka Community Kindergarten Association Inc. (ECKA) hereby confirm receipt of this notification. | | | |
|  | | | |
| Signature: |  | Date: |  |

|  |
| --- |
| **Requirements of injury notification:**   * Employers must keep a **Register of Injuries** at each workplace for employees to record any workplace injury or illness. * An injured worker (or someone acting on their behalf) must notify the employer in writing of any work-related injury or illness within 5 days of becoming aware of the injury or illness. * Employers must provide written confirmation to the injured worker that they received notification of the injury or illness. * Employers should provide a signed and dated copy of this entry to the injured worker. * To make a WorkSafe claim the injured worker must complete a *Worker’s Injury Claim Form*. |