1. **Scope of Work Injury Report**
   
   1.1 Covers all employees of the Department and students at any TAFE Institute within the Department of Employment, Training and Industrial Relations, including travel to and from the workplace.
   
   1.2 Where necessary WorkCover Queensland claim forms must also be completed and attached to this report.

2. **Guide to completing report**

   2.1 In **Part A&B**, the Person in Charge should have the injured person complete and sign the section. If the injured person is unable to enter the details the Person In Charge can record the facts on obtaining information from the injured person. **All information must be completed.**

   2.2 **Part B-6** requires specific details of the actual occurrences which took place before, during and after the incident. It is necessary only to state facts; do not offer opinions on where responsibility for the incident lies.

   **Correct**
   
   Eg. While using a pedestal drilling machine to drill through a 10mm steel plate, the drill bit broke injuring Mr. Jones on the area of the left eye. Safety glasses were not worn at the time.
   
   **Incorrect**
   
   Eg. Due to the poor condition of drills in the section Mr. Jones sustained an eye injury when one drill bit broke while he was using the pedestal drilling machine. He was not wearing safety glasses at the time as he finds them uncomfortable.

   2.3 In **Part C** - Person in Charge means - person immediately supervising activity at the time of the accident.

3. **Parts D, E & F** require the Health and Safety Representative/Risk Manager to conduct the investigation. Where a serious injury occurs contact Legal & Risk Management Services, telephone 3225 2080 and follow procedures as required under Workplace Health and Safety legislation.

4. Completed original form to be forwarded to the person in your Institute/Region/Division responsible for workplace health and safety. In the case of Institutes, it is usually a Risk Manager, in Divisions and Regions, your Executive Officer. They will arrange for this information to be recorded locally or forwarded to Legal and Risk Management Services, Business Development Division, GPO Box 69, BRISBANE 4001.
To comply with the Workplace Health and Safety Act 1995, a record of all work injuries, work caused illnesses and dangerous events must be recorded WITHIN THREE DAYS of receiving notification of the incident.

Ensure this form is forwarded as detailed on Page 1.

Please print clearly - complete all parts.

**PART A – PERSONAL DETAILS**

| 1. Employee ☐ Student ☐ Visitor ☐ Client ☐ Contractor ☐ Volunteer ☐ |
| 2. Surname: ____________________ Given Names: ____________________ |
| 3. Salutation: Mr / Mrs / Miss / Ms / Dr / Other (give details) ____________________ |
| 4. Sex: Male ☐ Female ☐ |
| 5. Employee Number (if DETIR employee): ____________________ |
| 6. Date of Birth: _________ / _________ / _________ |
| 7. Contact Telephone Number(s): ____________________ Occupation: ____________________ |
| 8. Residential Address: ____________________ |

**PART B – INCIDENT DETAILS**

| 1. Date of Incident: ____________________ Time of Incident: _________ am/pm |
| 2. Date Reported: ____________________ Time Reported: _________ am/pm |
| 3. Location - Institute/Business unit: ____________________ |
| 4. Business Address: ____________________ |
| 5. Location - Specifics (eg. Staff room, Block B): ____________________ |
| 6. Description of Incident: ____________________ |

7. Signature (injured person if available): ____________________

8. Nature of injury:

| ☐ 200 Laceration/Abrasion | ☐ 209 Fume inhalation |
| ☐ 201 Amputation | ☐ 210 Puncture |
| ☐ 202 Bruise | ☐ 211 Poisoning/toxic effects |
| ☐ 203 Dislocation | ☐ 212 Heat/cold stress |
| ☐ 204 Strains/Sprains | ☐ 213 Skin Irritation |
| ☐ 205 Burns/Skalds | ☐ 214 Infection/Disease |
| ☐ 206 Fracture | ☐ 215 Industrial Deafness |
| ☐ 207 Weld Flash | ☐ 216 Psychological Stress |
| ☐ 208 Foreign Body | ☐ 217 Multiple Injuries |
| | ☐ 218 Other (must specify) ____________________ |
PART B – INCIDENT DETAILS Continued

Bodily location:

- Head
- Finger
- Foot
- Eye
- Chest
- Toe
- Ear
- Back
- Abdomen
- Multiple Locations
- Nose
- Hips
- General (e.g. respiratory system, skin)
- Teeth
- Knee
- Psychological Condition

100 108 116
107 109 117
102 110 118
106 112 119
103 111 120
104 113 121
105 114 122

Agency of injury:

- Plant - Portable power tools
- Radiation (including welding flash)
- Plant - fixed
- Vehicle Private
- Plant - Mobile
- Vehicle Government
- Manual Handling
- Chemicals or Poisons
- Transport
- Repetitive movements
- Person falling, tripping, slipping
- Outdoor/Indoor environment
- Objects falling
- Needlestick
- Striking against
- Contact with Biological Agent
- Projects
- Other (must specify)
- Electricity
- Workplace Aggression

11. DESCRIPTION AND LOCATION OF PERSONAL DAMAGE

Location: Indicate type of damage at each side with appropriate letters

FRONT VIEW

- Right
- Left

BACK VIEW

- Left
- Right

DAMAGE TYPE

- AM Amputation
- AS Asphyxiation
- BR Bruise
- BU Burn
- CO Concussion
- DE Dermatitis
- DI Dislocation
- FB Foreign Body
- FR Fracture
- HE Hernia
- IN Inflammation (incl.infection)
- II Internal Injury
- LA Laceration/Cut
- OW Open Wound
- OA Dislocation
- SS Strain/Sprain/Back
- OT Other

PART C – OUTCOME OF INCIDENT

1. Treatment provided:
   - Injured/ill person -
     - Treated by First Aid
     - Referred to Doctor
     - Referred to Hospital
     - Returned to work/class
     - Unfit for work/Returned home
     - Returned to alternative duties

2. Transported to doctor/hospital by -
   - Private Vehicle
   - Ambulance
   - Taxi
   - Departmental Vehicle

3. Description of injuries/illness:

4. Description of first aid treatment given:

5. First aid provided by:

EV010 Version 5
6. Other associated people:

**Reported To:**
Surname ___________________ Given Names ___________________

Job Title: __________________

Employee Number __________________ Telephone __________________

**Person in Charge of Area:**
Surname ___________________ Given Names ___________________

Job Title: __________________

Employee Number __________________ Telephone __________________

**Witnesses:**
Surname ___________________ Given Names ___________________

Salutation: Mr / Mrs / Miss / Ms / Dr / Other (give details) __________________

Employee No. (if DETIR Employee) __________________

Residential Address: __________________

Contact telephone number: __________________

Surname ___________________ Given Names ___________________

Salutation: Mr / Mrs / Miss / Ms / Dr / Other (give details) __________________

Employee No. (if DETIR Employee) __________________

Residential Address: __________________

Contact telephone number: __________________

**PART D – INCIDENT INVESTIGATION DETAILS**

1. What were the actions that contributed to this incident? __________________
   __________________
   __________________
   __________________

2. What were the reasons for these actions? __________________
   __________________
   __________________
   __________________

3. What conditions contributed to this incident? __________________
   __________________
   __________________
   __________________

4. What were the reasons for these conditions existing? __________________
   __________________
   __________________
   __________________
PART E - REMEDIAL ACTIONS REQUIRED

1. Outline immediate action taken to prevent recurrence

2. What further action is recommended?

3. Action completed  Yes / No

4. Anticipated completion date  /  /

5. Person accountable to action recommendations (Name - please print)

PART F - ADDITIONAL INFORMATION

1. Next of Kin notified?  Yes  No

2. Additional comments (witness details, etc)

3. Police involved (details)

APPROVAL SIGNATURES (At least 2 of the following 3):

Person in Charge (Name – please print) ____________________________ Date  /  /

Signature ____________________________

Health & Safety Representative/Risk Manager ____________________________ Date  /  /

Signature ____________________________

Director/Manager ____________________________ Date  /  /

Signature ____________________________