Incident Report Form

PLEASE COMPLETE THIS REPORT IMMEDIATELY UPON NOTIFICATION OF AN EVENT, OCCURANCE OR CIRCUMSTANCE THAT MAY GIVE RISE TO A CLAIM FOR COMPENSATION FOR PERSONAL INJURY OR PROPERTY DAMAGE.

DO NOT ADMIT OR ACCEPT ANY LIABILITY.
PLEASE REFRAIN FROM PROVIDING ANY PERSONAL COMMENT AND STATE FACTS ONLY.

DETAILS OF PERSON REPORTING THE INCIDENT

Given Names _____ Surname _____

Role / Position _____

Address _____

Suburb _____ State _____ Postcode _____

Phone number _____

Email _____ Best time to contact _____

DETAILS OF AWARD UNIT

Award Unit Name _____

Postal Address _____

Phone number _____

Email _____ Web _____

DETAILS OF INJURED PARTY

Given Names _____ Surname _____ Sex M / F

Address _____

Suburb _____ State _____ Postcode _____

Date of Birth _____ Occupation _____

Phone Number _____ Email _____

DETAILS OF INCIDENT

Date of Incident _____ Time of Incident _____ : _____ AM / PM

Description of Incident _____

_____

_____

Details of Injury /Property Damage _____

_____

Location of Incident _____

Please provide a physical description of the person.		**Description of the clothing and footwear worn at the time of incident.**	
Was the person engaged in any activity that may have contributed to the incident? **i.e. - running, carrying a heavy load, drinking etc.** **If so, give details.**	Y / N *Please circle*		
Was the person eyesight or hearing impaired?	Y / N *Please circle*	**Did the person have a pre-existing medical condition or disability?** **If so, give details.**	Y / N *Please circle*
If applicable, what were the weather conditions at the time of the incident?			

REPORTER DETAILS AND ACTIONS TAKEN

Date reported _____ Time reported _____ : _____ AM / PM

Name of person informed of the incident.		**How was the person informed of the incident?** **(Phone, radio, letter, fax etc.)**		**Did you visit or attend the scene?** **If not, why?**	Y / N *Please circle*
Did the injured person require assistance? **Was the assistance refused?**	Y / N *Please circle* Y / N *Please circle*	**Assistance offered and/or treatment given**	No treatment / First Aid / Medical Provider / Ambulance & Hospitalisation *Please circle*		
Description of further action taken and/or follow-up treatment required.					
If applicable, provide details of any actions required to repair or replace defects?					

NAME OF PERSON REPORTING _____

SIGNATURE _____ **DATED** _____

DETAILS OF WITNESS

Given Names _____ Surname _____

Phone number _____ Email _____

DETAILS OF AWARD UNIT INSURANCE

Insurance Broker Name _____ Phone number _____

Postal Address _____

DETAILS OF ANY ACTIVITY OR SERVICE PROVIDERS

Insurance Broker Name _____ Phone number _____

Postal Address _____

DETAILS OF ANY ACTIVITY OR SERVICE PROVIDERS INSURANCE

Insurance Broker Name _____ Phone number _____

Postal Address _____

IMPORTANT NOTES

If possible, please obtain and attach the following information with the incident report:

- Photographs of the incident site
- Photographs of the injuries sustained
- Statements from all witnesses
- All other investigation reports and diary records

This form and any enclosures must be provided to the national award office either by fax (02) 02 9251 8993 or by email admin@dukeofed.com.au immediately upon completion.