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Appendix 7

Safety and Health Report Form (OHS 032/1)

(for Incidents, Hazards, Near Misses, Safety & Health Observations, etc.)

GENERAL DETAILS:							
Date and Time of the observation/event:				/ /			AM / PM
Person making report			First Name:				
Contact No:			Last Name:				
Department/Area:				Position Title:			
Name of person affected: (Please Tick ✓)				Same as above			Other:
First Name:			Last Name:				
Contact No:			Mobile:				
Relationship to Knox City Council: (Please Tick ✓)							
	Knox Council Employee		Volunteer		Client		Member of the public
	Contractor/Consultant/Agency staff (Name of Company, if known):						
	Other (please describe):						
Address and Location of observation/event:							
Person reported to: (Please Tick ✓)							
	Not Reported		Reported	First Name:			
Contact No:				Last Name:			
Department/Area:				Position Title:			

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DESCRIPTION:				
Describe observation/event:				
Have any corrective actions been taken in relation to this observation/event /hazard? (Please Tick ✓)				
	No		Yes	(If yes, please describe below):
Has this occurrence resulted in any person being injured or becoming ill? (Please Tick ✓)				
	No		Yes	(If yes, please describe below):

Please send completed form to: KCC Safety Risk & Wellbeing Team (People Performance):

Email: incidentreports@knox.vic.gov.au Fax: 9298 8539
For Help / Enquiries contact: Emil Turudia (WHS Advisor): 9298 8256

To find out why this information is collected and how it will be used, go to: eRIK>Health & Safety System page or contact the SRW Team.

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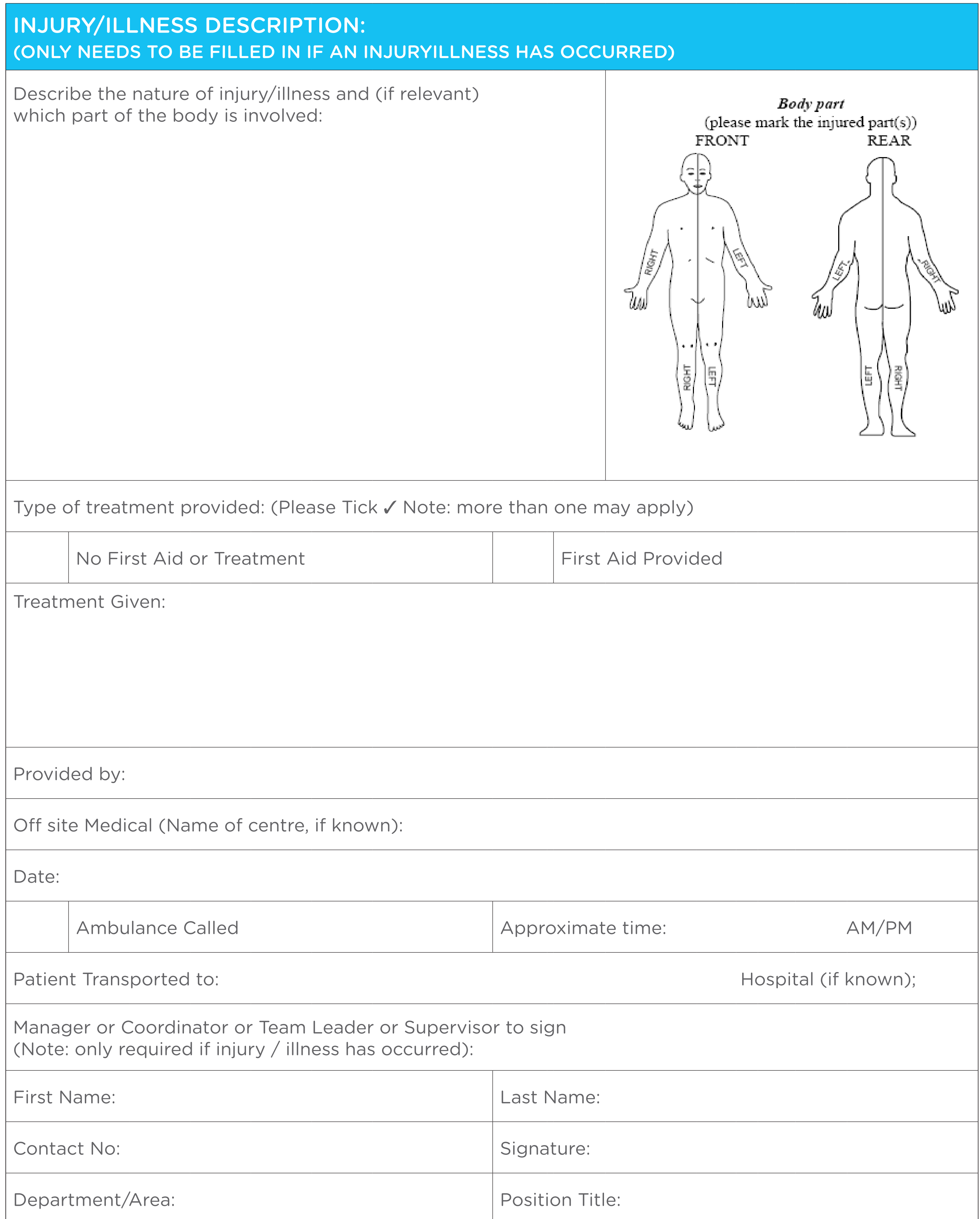

INJURY/ILLNESS DESCRIPTION:
(ONLY NEEDS TO BE FILLED IN IF AN INJURYILLNESS HAS OCCURRED)

Describe the nature of injury/illness and (if relevant) which part of the body is involved:

Type of treatment provided: (Please Tick ✓ Note: more than one may apply)

	No First Aid or Treatment		First Aid Provided

Treatment Given:

Provided by:

Off site Medical (Name of centre, if known):

Date:

	Ambulance Called	Approximate time: AM/PM

Patient Transported to: Hospital (if known);

Manager or Coordinator or Team Leader or Supervisor to sign
(Note: only required if injury / illness has occurred):

First Name:	Last Name:
Contact No:	Signature:
Department/Area:	Position Title:

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