



INCIDENT REPORT FORM

Please **Fax** to Masters Swimming Australia **03 9682 5444** or

Email: admin@mastersswimming.org.au

INSURED DETAILS									
Insured:		Contact Name:			Ph No:				
Date Reported:		Time Reported:		Exact Location:					
Date of Incident:		Time of Incident:		Day of week:					
Report Completed by:			Incident Reported to:						
Inspected By:		Time Location Inspected:							
PART 2: INJURED PERSON DETAILS									
Full name:		Date of birth:		Gender:		Male <input type="checkbox"/>		Female <input type="checkbox"/>	
Address:		Tel:		Mobile					
Walking Stick <input type="checkbox"/>		Glasses <input type="checkbox"/>		Carrying Goods <input type="checkbox"/>		Other Impairments <input type="checkbox"/>			
PART 3: WITNESS *DETAILS									
*Eyewitnesses witnessed the incident: circumstantial witnesses witnessed the events leading up to or following the incident. Additional witnesses' details should be provided in attachment.									
Witness Details									
Witness name 1:		Tel:		Address:					
Type of Witness:		Eye Witness <input type="checkbox"/>		Circumstantial Witness <input type="checkbox"/>		Relationship to Injured Person:			
Witness name 2:		Tel:		Address:					
Type of Witness:		Eye Witness <input type="checkbox"/>		Circumstantial Witness <input type="checkbox"/>		Relationship to Injured Person:			
IF ANOTHER PARTY RESPONSIBLE FOR THE INCIDENT, PLEASE PROVIDE DETAILS:									
PART 4: INJURY DETAILS									
Part of body injured (place tick in appropriate box)									
Head & Neck <input type="checkbox"/>		Hip <input type="checkbox"/>		Hands/Fingers <input type="checkbox"/>		Eyes or Face <input type="checkbox"/>		Shoulder <input type="checkbox"/>	
Knee <input type="checkbox"/>		Back and Trunk <input type="checkbox"/>		Arms/Wrists <input type="checkbox"/>		Feet/Ankles or Toes <input type="checkbox"/>		Teeth/Mouth <input type="checkbox"/>	
If other please specify:									

Nature of Injury (Place tick in appropriate box)											
Multiple	<input type="checkbox"/>	Minor Bruise – Not disabling	<input type="checkbox"/>	Concussion/Unconscious (serious)	<input type="checkbox"/>	Fracture	<input type="checkbox"/>	Major Bruising/Disabling	<input type="checkbox"/>	No Apparent Injury	<input type="checkbox"/>
Sprain	<input type="checkbox"/>	Minor Cut/Laceration – No stitches	<input type="checkbox"/>	Superficial	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	Cut/Laceration requiring stitches	<input type="checkbox"/>		
Ligament Damage	<input type="checkbox"/>	Minor Concussion	<input type="checkbox"/>	Head/Face	<input type="checkbox"/>	Knee	<input type="checkbox"/>	Burns/Scalds – requiring medical attention	<input type="checkbox"/>		
If other please specify:											
OF and SEQUENCE OF EVENTS LEADING UP TO THE INCIDENT (as described by injured party)											
DESCRIPTION OF INCIDENT (by you or independent witness)											
WAS INJURED PERSON TAKEN TO		TREATMENT BY FIRST AIDER <input type="checkbox"/>				DOCTOR/HOSPITAL <input type="checkbox"/>		AMBULANCE <input type="checkbox"/>			
NAME OF FIRST AIDER/PERSON ATTENDING:						CONTACT PHONE NO:					
<input type="checkbox"/> OTHER (please describe)											
Was the incident a result of the actions of another party (eg Contractor, visitor)? Yes <input type="checkbox"/> Provide details below No <input type="checkbox"/>											
Full name:						Tel:					
Address:											
Was the incident captured on CCTV/digital recording? Yes <input type="checkbox"/> No <input type="checkbox"/>											
PART 5: PROPERTY DAMAGE DETAILS (if relevant)											
ITEM DAMAGED:						DETAILS:				APPROX. VALUE	\$
IF VIEWED AND BY WHOM:						PHOTOS TAKEN AND BY WHOM:					
PART 6: LOCATION OF INCIDENT (Please tick in appropriate box)											
Car park	<input type="checkbox"/>	Entrance /Exit	<input type="checkbox"/>	Stairs	<input type="checkbox"/>	Ramp	<input type="checkbox"/>	Children's Play Area	<input type="checkbox"/>	Escalators	<input type="checkbox"/>
Amusement Ride	<input type="checkbox"/>	Sport Ground/Field/Stadium	<input type="checkbox"/>	Elevators	<input type="checkbox"/>	Toilet Areas	<input type="checkbox"/>	Food Court	<input type="checkbox"/>	Restaurants/Cafe/Food area	<input type="checkbox"/>
Common Areas/Walkway	<input type="checkbox"/>	Seats i.e In stadium	<input type="checkbox"/>	Swimming Pool	<input type="checkbox"/>	Animal Pen or area	<input type="checkbox"/>	Show area	<input type="checkbox"/>	Motor powered vehicle	<input type="checkbox"/>
Slide	<input type="checkbox"/>	Game	<input type="checkbox"/>	Beverage Area	<input type="checkbox"/>	Turn-Style					
If other please specify:											
PART 7: TYPE OF INCIDENT (Please tick in appropriate box)											
Slip and Fall of Person: Cause											
Chips	<input type="checkbox"/>	Lack of Barrier	<input type="checkbox"/>	Uneven Floor	<input type="checkbox"/>	Ice Cream	<input type="checkbox"/>	Rainwater on Floor	<input type="checkbox"/>	Tripped over Object	<input type="checkbox"/>
Beverage	<input type="checkbox"/>	Barrier/Signs	<input type="checkbox"/>	Steps/Stairs	<input type="checkbox"/>	Floor Slippery (Surface)	<input type="checkbox"/>	Vegetable/ Fruit Items	<input type="checkbox"/>	Car Park Stops/Bollards	<input type="checkbox"/>
Inadequate Lighting	<input type="checkbox"/>	Other Food	<input type="checkbox"/>	No apparent reason	<input type="checkbox"/>	Person Running	<input type="checkbox"/>	Vomit	<input type="checkbox"/>		
If other please specify:											

OR Caught in/hit by:							
Door	<input type="checkbox"/>	Escalator/ Elevator	<input type="checkbox"/>	Machinery	<input type="checkbox"/>	Other	<input type="checkbox"/>
If other please specify:							
OR fell off / injured by:							
Slide	<input type="checkbox"/>	Animal (describe type)	<input type="checkbox"/>	Ball	<input type="checkbox"/>	Amusement Ride (describe type)	<input type="checkbox"/>
						Another Patron	<input type="checkbox"/>
						Motor Powered Vehicle (describe type)	<input type="checkbox"/>
If other please specify:							
Stepping on or Striking Against:							
Display Stands	<input type="checkbox"/>	Escalator/Elevator	<input type="checkbox"/>	Doors	<input type="checkbox"/>	Sharp Edges/Protruding Objects	<input type="checkbox"/>
						Other	<input type="checkbox"/>
If other please specify:							
Other							
Falling objects	<input type="checkbox"/>	If falling object please describe					
Water Damage	<input type="checkbox"/>						
Type of Surface							
Marble	<input type="checkbox"/>	Tile	<input type="checkbox"/>	Carpet	<input type="checkbox"/>	Speed Hump	<input type="checkbox"/>
						Terrazzo	<input type="checkbox"/>
						Timber	<input type="checkbox"/>
Bitumen	<input type="checkbox"/>	Dirt/Grass/Garden	<input type="checkbox"/>	Slate	<input type="checkbox"/>	Vinyl	<input type="checkbox"/>
						Concrete	<input type="checkbox"/>
						Other	<input type="checkbox"/>
If other please specify:							
WAS INJURED PERSON	Reasonable	<input type="checkbox"/>	Upset	<input type="checkbox"/>	Aggressive	<input type="checkbox"/>	Comments:
Cleaner on Duty:					Cleaning Supervisor:		
Time location last inspected:					Time Last Cleaned:		