ACCIDENT/INCIDENT/HAZARD REPORT FORM

NOTE: All accidents, incidents or hazards are to be reported to Archerfield Airport Corporation. Reports should be made immediately if injuries/damage to property occurs and without delay in other cases

PART A: TO BE COMPLETED BY REPORTER

1. Details of Reporter

Reporter Name:		**Contact No.**	
Report Date:		**Status:** (*Tick appropriate box* below)	

Pilot		Tenant		Contractor		Visitor		AAC employee		Other	

2. Details of accident/incident/hazard (hereafter called "the incident")

Date of incident:	Time of incident:
Activity/Task being performed:	
Equipment involved:	
Location of event:	
Describe hazard or how the incident occurred and what happened *(Please give full details and include a diagram, if appropriate. Use a separate sheet if necessary. Please include car registration number if reporting a Motor Vehicle Accident)*:	

WAS ANYONE INJURED?	***YES***		***Complete all clauses***	***NO***		***Proceed to Clause 6***

3. Details of injured person:

Surname:	Phone: (h)			(w)	
First Name:	Sex:	M		F	
Address:	Date of Birth:				

Experience in job:									
0-3 months		4-12 months		1-2 years		3-5 years		5 years plus	
Casual		Part Time		Permanent		Other			

4. Details of injury *(IF APPLICABLE)*

Nature of injury / illness (e.g. burn, sprain, cut etc.):

How (e.g. fall, grabbed by person, muscular stress):

Location on body (e.g. back, right thumb, left arm etc.):

What contributed to the injury (e.g. furniture, another person, hot water):

5. Treatment administered (*IF APPLICABLE)*

Was First Aid administered?	Yes		No	

Treatment:

First Aid Attendant (Print Name):	Signature:
Name of Doctor visited:	Date Doctor visited:

6. Reporting

Was incident reported to Supervisor	Yes		No		Was incident reported to AAC	Yes		No	

Name of Supervisor who was notified of incident: _____ Date: _____	Date AAC was notified of incident and name of person notified: _____Date:_____

7. Details of witnesses:

Name:	Phone: (h) (w)
Address:	
Name:	Phone: (h) (w)
Address:	

PART B: TO BE COMPLETED BY SUPERVISOR / SENIOR STAFF MEMBER /AAC

Name of Person completing this section:	

7. Did the injured person stop work *(IF APPLICABLE)*

Yes		No		If yes, state date:	Time:

Outcome:

	Treated by Doctor		Lodged Workers Comp Claim		Date Workers Comp Form lodged:_____
	WH&S Authority notified		Returned to normal duties		Referred to Return to Work Coordinator
	Hospitalised		Returned to alternative duties		Referred to WH&S Coordinator

8. Incident investigation

(*Comments to include identified causal/contributing factors):*

9. Remedial/Corrective actions:

	Conduct task analysis		Re-instruct persons involved		Improve design/construction/ guarding
	Conduct hazard system audit		Provide debriefing and/or counselling		Add to inspection program
	Develop / review tasks procedures		Request maintenance		Improve communication / reporting procedures
	Improve work environment		Improve personal protection		Improve security
	Review WH&S policy/programs		Improve work congestion / housekeeping		Temporarily relocate employees involved
	Replace equipment / tools		Investigate safer alternatives		Falls Prevention Assessment
	Improve work organisation		Request MSDS (Material Safety Data Sheets)		Develop and/or provide training
	Other – specify:				

What, in your own words, has been implemented or planned to prevent recurrence:					
10. Remedial actions completed:	**Yes**		**If Yes date completed: _____**	**No**	
Signature of Supervisor:			Date:		

PART C: TO BE COMPLETED BY AAC GENERAL MANAGER

11. Review comments	
Reviewed by General Manager (Signed):	Date:
12. Payroll	
Copy of report sent to payroll (Yes/No):	Date Sent: