

Issue No. 01 Revision No. 02

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

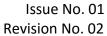
PART A: TO BE COMPLETED BY REPORTER									
1. Details of Reporter									
Reporter Na	me:					Contact No) .		
Report Date:						Status: (Tick appropriate box below)			
Pilot		Tenant	Contracto		Visitor	AAC employ	ee	Other	
2. Details of accident/incident/hazard (hereafter called "the incident")									
Date of inciden	it:					Time of incident:			
Activity/Task b	eing pe	rformed:							
Equipment invo	olved:								
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					olete all clauses	NO	NO Proceed to Clause 6		
3. Details of injured person:									
Surname:)		(w)		
First Name:				Sex:	M		F		
Address:				Date of B	Date of Birth:				



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Experience in job:												
0-3 months		4-12 months	5	1-2 ye	ars		3-5 years		5 years plus			
Casual		Part Time		Permar	ient		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 contribute	d to the	e injury (e.g. fu	rniture, a	nother per	son, hot v	water):						
5. Treatment administered (IF APPLICABLE)												
Was First Aid administered? Yes No												
Treatment:												
First Aid Attenda	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 AAC was notified of incident and name of person notified									ied:			
Date:Date:												
7. Details of witnesses:												
Name:							Phone: (h)		(w)			
Address:												
Name:							Phone: (h)		(w)			
Address:												

Phone: 07 3275 8000 Issue Date: May 2016





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:			
Out	Outcome:									
Treated by Doctor Lo					Lodged Workers Comp Claim	Dat	e Workers Comp Form lodged:			
WH&S Authority notified Re				t	Returned to normal duties	Ref	ferred to Return to Work Coordinator			
	Hospita	lised			Returned to alternative duties	Ref	erred to WH&S Coordinator			
8. In	cident i	nvesti	gation			l l				
(Com	ments to	include	identified	d causal/con	tributing factors):					
9. R	emedial	/Corre	ective ac	ctions:						
					Do instruct persons involve	od	Improve design/construction/guarding			
		task analysis Re-instruct persons involved		eu	Improve design/construction/ guarding					
	Conduct hazard system audit Provide debriefing and/or counselling Add to inspection program									
	Develop /	review			Improve communication / reporting procedures					
	Improve v	vork environment Improve personal protection		on	Improve security					
	Review W	Review WH&S policy/programs Improve work congestion / Temporarily relocate employees housekeeping				Temporarily relocate employees involved				
	Replace equipment / tools Investigate safer alternatives Falls Prevention Assessment									
	Improve v	work or	ganisation	n	Request MSDS (Material Safety Data Sheets)		Develop and/or provide training			
	Other – specify:									

Form No. OPS-10 Accident/Incident/Hazard Report



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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:					
DADT 0 TO D	E 60145	WETER RV AAC OFNERAL AAANA	OFD.				
PART C: 10 B	E COMP	PLETED BY AAC GENERAL MANA	GEK				
11. Review comments							
Reviewed by General Manager (Signed):		Date:					
12. Payroll							
Copy of report sent to payroll (Yes/No):		Date Sent:					