



Incident Report

All Incidents be they Near Miss; Actual Injury or Shed Incidents, are to be investigated, reported and recorded. The information gathered may be required by Insurers. Issues arising out of the investigation may also be communicated to other Sheds via the AMSA/State MSA to help prevent a recurrence.

Report No.:	Men's Shed Location:
Date of Incident:	Time of Incident:

PART A: DESCRIPTION OF WHAT HAPPENED:

Type of Incident:	
<p>Physical Injury or Medical Episode:</p> <p><input type="checkbox"/> Immediate First Aid Applied:</p> <p><input type="checkbox"/> Medical Treatment:</p> <p><input type="checkbox"/> Lost Time Injury:</p>	<p>If Non – Injury, Was the Incident Due To:</p> <p><input type="checkbox"/> Fire</p> <p><input type="checkbox"/> Explosion</p> <p><input type="checkbox"/> Plant Failure</p> <p><input type="checkbox"/> Plant Damage</p> <p><input type="checkbox"/> Other (Specify):</p>

PART B: WHAT & HOW DID IT HAPPEN:

Description of Incident: Explain clearly what and how the incident occurred.

Description should be **brief, in dot point** form providing **the facts only**.

The location within the shed (attach a sketch/map) and what the weather conditions were.

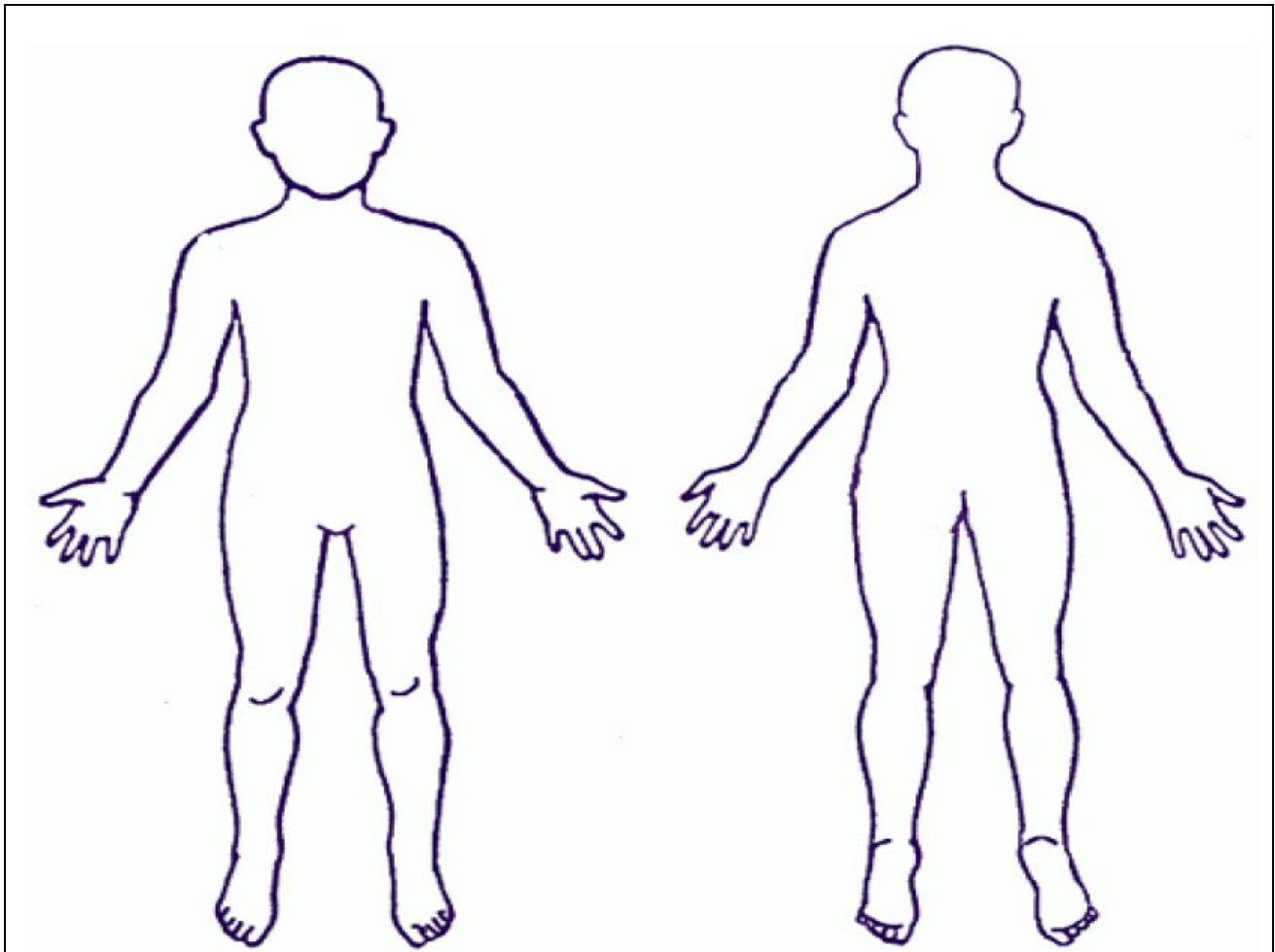
DO NOT include supposition and hearsay).

PERSON(S) DIRECTLY INVOLVED:

Member(s) Name	Phone Number	Address
Non - Member(s) Name		

PART C: INJURY REPORT: Indicate on the Body Chart below the Type of, and Injured Part of the Body.

Broken Bone(s)	Dislocation	Cuts / Lacerations	Bruise
Sprain/Strain	Multiple Injuries	Crush Injury	Other



Injury Details:

Was First Aid Treatment Administered?

- Yes
- No

If Yes – Details of Treatment:

What First Aid measures were carried out:

-
-
-

Who performed First Aid;

-

Was the Injured Person:

1. Able to continue shed activities?

- Yes
 No

2. Able to go home safely?

- Yes
 No

3. Advised to see their Doctor

- Yes
 No

4. Required to go to Hospital either with Family Member or Shedder assistance or by Ambulance?

- Yes
 No

(cont.)

If the response is YES to 3 & 4 , please provide the Name of the

- Doctor/Hospital.
- Family Member
- Shed Member

Please attach Medical Certificate/Certificate of Capacity Documentation.

Did the Injured Person return to the Shed to participate.

- Yes
 No

Additional Relevant Injury/Incident Information If Required:

PART D: AUTHORITY NOTIFICATION(S):

IS THIS A MAJOR/SERIOUS INCIDENT?

- YES
- NO

NAME OF RELEVANT AUTHORITY e.g. POLICE / FIRE / AMBULANCE NOTIFIED

- YES
- NO

PART E: AUTHORISATION AND DISTRIBUTION:

REPORT PREPARED

BY: _____

NAME: _____

SIGNATURE: _____

DATE: _____

DISTRIBUTION OF FORM : TO SHED EXECUTIVE AND COMMITTEE