APPENDIX 3

HAZARD/INCIDENT REPORT

In the event of the identification of any hazards or incidents please complete the following and submit to management.

Project:____ Date_________________

Submitted by:

____

Signature:

____

Submitted to:

____

Root Cause: ☐ **New Hazard** ☐ **Behavioural Deficiency** ☐ **Training Deficiency**

What went wrong? :

To be completed by Manager

Action required:

By whom: ____

When: ☐ **Immediate** ☐ **Within 24 hours** ☐ **Within 7 days**

Corrective action completed by:______________________________________

Time:_____________ am/pm Date: _______________________________

Signature: ____

Confirmed by:___________________ Signature: _______________________

APPENDIX 4

OHS INCIDENT AND/OR INJURY/ILLNESS REPORT FORM

In the event of any work-related injury or illness associated with the INH sites, the subcontractor is required to notify of such by the completion of the Injury/Illness Report. This form is then to be submitted to the Project Manager as soon as practicable.

SIGNIFICANT INCIDENT AND/OR INJURY/ILLNESS REPORT

Details of injured/ill person:

Name

Surname: ______________________________ Given Name/s: _________________________

Address

No: _______________ Street:____

Suburb: _________________ Postcard: __________ Contact Phone No: _______________

Employer

Business Name: ____

Address

No: _______________ Street:____

Suburb: _________________ Postcard: __________ Contact Phone No: _______________

Accident/Incident Details:

Description of Events

Date of injury/illness: ____________________ Time of injury/illness: ________________

Task / operation undertaken at the time of injury/illness:

Physical location (area) where injury/illness occurred:

Type of injury: e.g. bruise, cut, fracture

Part of body injured:

Cause of injury/illness: (What happened?)

Treatment given/action taken:

Person completing this form (Project Manager, Construction Manager or Regional Manager):

Surname: ________________________________ Given Name/s: _______________________

Signature: _____________________________ Date: __________ Time: ___________am/pm

Did the person injured or sick cease work? ☐ Yes ☐ No

Has a referral for further treatment been issued? ☐ Yes ☐ No