

Doc. 11.2 AMSA Incident Report Form

AMSA report forms 18 and/or 19 will need to be completed.

VESSEL DETAILS

Describe the incident: Who, what, when, where and how – what happened?

What created the risk?

What actions have you taken to prevent similar incidents in the future?

RISK ASSESSMENT

Did similar incidents occur previously?

Yes No

Was risk assessment conducted for this activity?

Yes No

Did the risk assessment highlight any concerns with the activity?

Yes No

Risk assessment reviewed?

Yes No

Doc. 11.2 SASRS First Aid / Incident / Injury Report Form

Tick the Correct Box and Print Clearly

Status: Volunteer. Employee. Contractor. Passenger.
Outcome: Near miss. Injury. Property Damage.

1. DETAILS OF PERSON INVOLVED

Name: _____ Phone: (H) _____ (W) _____
Mobile: _____
Address: _____ Sex: M F
Date of birth: _____
Position: _____
Experience in the Job: _____ (Years / Months)
Start Time: _____ AM PM
Work Arrangement: Voluntary Casual Full-time Part-time Other

2. DETAILS OF INCIDENT_ (If Insufficient Space Please Attach Extra Sheet)

Date: _____ Time: _____
Location: _____
Describe What Happened and How: _____

3. DETAILS of WITNESSES

Name: _____ Phone: (H) _____ Mobile: _____
Address: _____

4. DETAILS OF INJURY

Nature of injury (e.g. Burn, Cut, Sprain) _____
Cause of injury (e.g. Fall, Grabbed by Person) _____
Location on body (e.g. Back, Left Forearm) _____
Agency (e.g. Lounge Chair, Another Person, Hot Water)

5. TREATMENT ADMINISTERED

First Aid given Yes No Ambulance Attended Conveyed to Hospital / Medical Centre

First Aider Name: _____ First Aider Signature: _____

Treatment: _____

Referred to: _____

**SECTION 6-9 MUST BE COMPLETED BY EMPLOYER
or PCBU (person conducting a business undertaking)**

6. DID THE INJURED PERSON STOP WORK?

Yes No N/a If yes, state date: _____ Time: _____

Outcome:

- Treated by doctor Hospitalised Workers compensation claim
 Returned to normal work Alternative duties Rehabilitation Insurance claim

7. INCIDENT INVESTIGATION (comments to include causal factors):

8. RISK ASSESSMENT

Likelihood of recurrence: _____

Severity of outcome: _____

Level of risk: _____

9. ACTION REQUEST TO PREVENT RECURRENCE

Raised by	Priority please circle	Please circle appropriate descriptor of type of incident			
Date raised		Safety	Non conformance	Near miss	Opportunity for improvement
Action required	By whom	By when	Date completed		

10. VERIFICATION OF ACTIONS COMPLETED

Signed : _____ Title: _____
 Date: _____
 Feedback to person involved Date: _____

11. REVIEW COMMENTS

Any accident/incident/injury/outcomes and actions are to be reviewed by the SASRS Executive

Executive Meeting: Date:

Reviewed by Commodore (signature): _____ Date: _____

Reviewed by Operations Captain (signature): _____ Date: _____

Reviewed by SASRS WHS rep (signature): _____ Date: _____

