

ACCIDENT, INCIDENT or NEAR MISS REPORT FORM

When to Use this Form

1. To report any Accident, Incident or Near Miss.
2. This form should be completed by the person involved, forwarded to their immediate supervisor or the supervisor of the area where the hazard has been identified or the incident occurred for review and action. A report is required for each injured party if more than one person is injured
3. The supervisor should complete the form if the person involved is not available to do so.

Part A: INCIDENT LOCATION				
Work Area:	Report–Accident\Incident\Near Miss		Location: (Circle Location)	Darwin Alice Springs Tennant Creek
Business Unit:			Department:	
Area/Project:			Detailed Description	
Match information provided above to the available filters when entering into RMSS. If no suitable filter is available contact HSE Department - Ext 969				
Date of Incident	Time of Incident	Incident Type Accident\Incident\Near Miss Report		Incident Severity Low Medium High Extreme
Incident Outcomes <input type="checkbox"/> Injury <input type="checkbox"/> Vehicle Incident <input type="checkbox"/> Environmental Incident				
Part B: REPORTED BY				
First Name		Last Name		
Phone Number:	Mobile Phone Number:	Email Address:		
Occupation/Place of Employment				
Part C: INCIDENT DETAILS Attach sheets if insufficient space				
Actual Location?				
Activity at Time? (e.g. driving a forklift, lifting bags of cement, typing)				
Describe the Incident. (Include the name of chemicals, process or equipment involved)				
Contributing Factors? (e.g. brakes failed, slipped on wet floor, arm started hurting while typing)				
What Actions Were Taken Immediately?				

**If No Injury, Illness, Environmental Impact or Motor Vehicles Are Involved
Proceed to Page 4**

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Part D: INJURY/ILLNESS DETAILS			This section must be completed if an injury has occurred		
Injured Person Details					
Title	First Name	Last Name			
Home Phone Number:	Mobile Phone Number:	Email Address:			
Additional Comments:					
Injury Classification					
(please tick one (1) only) <input type="checkbox"/> Slip/Trip/Fall <input type="checkbox"/> Hit by Moving Object <input type="checkbox"/> Cut/Abrasion <input type="checkbox"/> Electric Shock/Electrocution <input type="checkbox"/> Crush Injury <input type="checkbox"/> Sprain/Strain <input type="checkbox"/> Chemical Exposure <input type="checkbox"/> Inhalation <input type="checkbox"/> Bite <input type="checkbox"/> Burn <input type="checkbox"/> Fracture or Broken Bones <input type="checkbox"/> Other					
If other please specify					
Nature of Incident - Briefly describe the nature of the injury ie Slip, Burn Crush etc. (If unsure leave blank)					
Match information provided above to available filters when entering into RMSS. If no suitable filter is available contact HSE Department - Ext 969					
Agency of Incident - Briefly describe what object or item caused the injury ie. Machinery, Chemicals, Stairs etc. (If unsure leave blank)					
Match information provided above to available filters when entering into RMSS. If no suitable filter is available contact HSE Department - Ext 969					
Mechanism - Classify the injury causes ie. Muscle Strain, Fall from Height, Exposure to Radiation etc. (If unsure leave blank)					
Match information provided above to the available filters when entering into RMSS. If no suitable filter is available contact HSE Department - Ext 969					
How were the Injuries Sustained					
Injured Members Occupation:					
(please tick one (1) only) <input type="checkbox"/> ADG - Staff <input type="checkbox"/> ADG Tenant- Staff <input type="checkbox"/> ADG - Contractor <input type="checkbox"/> Member of the Public <input type="checkbox"/> ADG - Visitor <input type="checkbox"/> ADG Tenant - Visitor <input type="checkbox"/> ADG Tenant -Contractor <input type="checkbox"/> Other					
If other please provide details:					
Treatment Outcome Details:					
(please tick one (1) only) <input type="checkbox"/> No Treatment <input type="checkbox"/> Medical Treatment Injury - MTI <input type="checkbox"/> Fatality <input type="checkbox"/> First Aid Injury - FAI <input type="checkbox"/> Lost Time Injury - LTI					
Treated By:					
<input type="checkbox"/> Doctor <input type="checkbox"/> Hospital <input type="checkbox"/> Home <input type="checkbox"/> Restricted Duties <input type="checkbox"/> Return to Work					
First Aid Details					
First Aiders Name					Contact Ph
Doctors Name			Surgery/Hospital	Contact Ph	
Location of Injury/s <small>(i.e. Left Hand, Left Foot, Neck)</small>					
Match information provided above to the available image in RMSS. If no suitable filter is available contact HSE Department - Ext 969					
Any Additional Injury Details					

Part E: Environmental Incident		This section must be completed if "Environmental Damage" occurred due to the incident	
A spill reporting form MUST also be completed if this section is used			
Nature of Impact (What Happened) (please tick one (1) only)			
<input type="checkbox"/> Spill	<input type="checkbox"/> Loss of Containment	<input type="checkbox"/> Dust	<input type="checkbox"/> Sabotage
<input type="checkbox"/> Gas Release	<input type="checkbox"/> Grass or Bush Fire	<input type="checkbox"/> Illegal Dumping	<input type="checkbox"/> Other
If other please provide details: _____			
Aspect Effected (Where To) (please tick one (1) only)			
<input type="checkbox"/> Seal Surface	<input type="checkbox"/> Broken Ground	<input type="checkbox"/> Atmosphere	
<input type="checkbox"/> Creek or Waterway	<input type="checkbox"/> Storm Water Drain	<input type="checkbox"/> Ground Water	<input type="checkbox"/> Other
If other please provide details: _____			
Impacting Agent (What) (please tick one (1) only)			
<input type="checkbox"/> Diesel	<input type="checkbox"/> Jet A1	<input type="checkbox"/> Herbicide	<input type="checkbox"/> Pesticide
<input type="checkbox"/> Avgas	<input type="checkbox"/> Engine Oil	<input type="checkbox"/> Hydraulic Oil	<input type="checkbox"/> Sewage
		<input type="checkbox"/> Poisons	<input type="checkbox"/> Coolant
			<input type="checkbox"/> ULP
If other please provide details: _____			
How much was spilt (Approximate Quantity)		Unit of Measure	
Area effected (Approximate Area)		Unit of Measure	
Further Details			

Part F: DRIVER & VEHICLE DETAILS		This section must be completed for a motor vehicle incident	
Road Type (please tick one (1) only)	<input type="checkbox"/> Sealed	<input type="checkbox"/> Unsealed	
Road Quality (please tick one (1) only)	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Average <input type="checkbox"/> Poor
Visibility (please tick one (1) only)	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Average <input type="checkbox"/> Poor
Weather (please tick one (1) only)	<input type="checkbox"/> Dry & Sunny	<input type="checkbox"/> Light Showers	<input type="checkbox"/> Heavy Showers <input type="checkbox"/> Cyclone
	<input type="checkbox"/> Dry & Overcast	<input type="checkbox"/> Moderate Showers	<input type="checkbox"/> Storms or Squalls
Have the Police Been informed Police?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Vehicle Type (please tick one (1) only)	<input type="checkbox"/> Car (C Class)	<input type="checkbox"/> Ute (C Class)	<input type="checkbox"/> Motor Cycle <input type="checkbox"/> Wagon or Van (C Class)
	<input type="checkbox"/> Truck (LR Class)	<input type="checkbox"/> Truck (MR Class)	<input type="checkbox"/> Truck (HR Class) <input type="checkbox"/> Articulated Vehicle (HC or MC Class)
Vehicle Make/Model	Vehicle Rego No	Expiration Date	
Drivers Details			
Title	First Name	Last Name	Home Phone Number:
Mobile Phone Number:	Email Address:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:
Drivers License Type (What "Class" of License)	Drivers License No & Expiration Date	Issuing State	
	/ /		
Describe the damage to the vehicle/s			
Is the vehicle Drivable	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where any passengers in the vehicle at the time of the incident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Title	Passenger Surname	Passenger Given Name/s	Contact Ph
Title	Passenger Surname	Passenger Given Name/s	Contact Ph
Title	Passenger Surname	Passenger Given Name/s	Contact Ph
Was another vehicle involved?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the other vehicle drivable	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vehicle Registration No.	Vehicle Make/Model	Vehicle Registration Expiration Date	/ /
Describe the damage to the vehicle/s			
Was the incident reported to the Police?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Police Report No.	

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**ADG Staff please sign below then forward this form to your supervisor for completion.
All other members please sign below and give to ADG Customer Service Manager or the HSE Coordinator:**

I declare the information provided in this form to be a true account of the Hazard/Incident. I acknowledge that Airport Development Group may need to disclose details of this report, including personal details, to relevant third parties.

Signed		Date:	/ /
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WORK AREA MANAGER IS REQUIRED TO ENTER INCIDENT DATA ONTO RMSS & TO FORWARD A COPY TO HSE DEPARTMENT UPON RECEIPT OF COMPLETED FORM:

All Data entered onto RMSS Incident Reporting Module

Investigation Assigned to:	Name:	Date:
Signed		Date: