Facility Management Victoria Pty Ltd

Accident / Incident Report Form

Please ensure all questions are clearly answered, and
fax to head office 03 9690 1366 or emailed to office@fmv.net.au, within 24 hours

Personal details:	
Surname:	First name:
Address:	
Town /Suburb	State Postcode
Occupation:	Work Location:
Date of incident:	Time of incident:
Was work recommenced after accident/incident: Yes / No (please circle)	
Date work ceased:	Time work ceased:

Type of injury:		**(please tick the box(s) that apply)**			
Allergic reaction		Fracture		Occupational disease	
Foreign body		Burns		Scratches	
Sprains & strains		Bruises		Crush injury	
Cuts/lacerations		Bites		Other(specify):	

Part(s) of body injured:		**(please tick the box(s) that apply)**			
Abdomen		Head		Eye	
Multiple injuries		Lower limb		Back	
Other		Upper limb		Other	
If 'other' please explain					

Severity of injury:	**(please tick)**						
Fatality:		Serious injury:		Moderate (doctor visit):		Minor(non - doctor visit):	

Treatment given by:	**(please provide name)**		
First aider:		Clinic:	
Doctor:		Hospital:	
Other:		Date of treatment	

Accident/Incident details	(please circle or write answer)
Was another person injured?	Yes / No
If 'yes' name of person injured:	
Was property damaged? Yes / No	Was a vehicle involved? Yes / No
Vehicle type:	Plant no:

Please complete for all accidents, incidents and near misses
Describe details of accident / incident / near miss ____ ____ ____ ____ ____ ____ ____ ____

Please complete for all accidents, incidents and near misses
Location of accident / incident / near miss:________________________ ____ ____ ____

Comments:____
____ ____ ____ ____ ____________________

Name of person filling in this form:	
Signature:	Date:
Name of witness to accident/incident:	
Signature:	Date:

Manager to immediately ring 13 23 60 (Victorian WorkCover Authority) when a fatality or serious injury occurs, or there is a dangerous occurrence.
If necessary, date Victorian WorkCover Authority notified: