



### 3.2. Incident Details (continued) — Person reporting the incident to complete

Nature of injury, illness or symptom	Asthma or other respiratory illness	<input type="checkbox"/>	Amputation	<input type="checkbox"/>	Psychological	<input type="checkbox"/>
	Bruise, contusion or crushing injury	<input type="checkbox"/>	Burn	<input type="checkbox"/>	Sensory loss	<input type="checkbox"/>
	Dermatitis or other skin conditions	<input type="checkbox"/>	Concussion	<input type="checkbox"/>	Sprain/Strain	<input type="checkbox"/>
	Effects of exposure to the elements	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	Superficial injury	<input type="checkbox"/>
	Foreign matter intrusion	<input type="checkbox"/>	Electric shock	<input type="checkbox"/>	Other (specify)	
	Needlestick or sharp injury	<input type="checkbox"/>	Fracture	<input type="checkbox"/>		
	Poisoning or effects of substances	<input type="checkbox"/>	Internal injury	<input type="checkbox"/>		

Location of injury, illness or symptom	Ear	<input type="checkbox"/>	Hand or finger	<input type="checkbox"/>	Back	<input type="checkbox"/>	Multiple locations	<input type="checkbox"/>
	Eye	<input type="checkbox"/>	Internal organs	<input type="checkbox"/>	Neck	<input type="checkbox"/>	Not applicable	<input type="checkbox"/>
	Face	<input type="checkbox"/>	Feet or toes	<input type="checkbox"/>	Shoulder or arm	<input type="checkbox"/>	Other (specify)	
	Head(not eye/ear/face)	<input type="checkbox"/>	Hip or leg	<input type="checkbox"/>	Trunk	<input type="checkbox"/>		

How did the injury, illness or symptom occur?	Select the action	Specify the object	Select the action	Specify the object
	<i>For example:</i> Exposure to <input checked="" type="checkbox"/> a chemical Contact with <input checked="" type="checkbox"/> electricity Bite from <input checked="" type="checkbox"/> an animal Fall from <input checked="" type="checkbox"/> same level	Bite from	<input type="checkbox"/>	
Contact with		<input type="checkbox"/>		
Exposure to		<input type="checkbox"/>		
Fall from		<input type="checkbox"/>		
Hit by		<input type="checkbox"/>		
Other (specify)				
	Hitting	<input type="checkbox"/>		
	Muscular stress from	<input type="checkbox"/>		
	Trapped between	<input type="checkbox"/>		
	Trapped by	<input type="checkbox"/>		
	Vehicle Accident	<input type="checkbox"/>		

Name of injured persons' supervisor

*(The incident report will be sent to the above person.)*

Signature of injured person	<input type="text"/>	Date	<input type="text"/>
Signature of person reporting incident	<input type="text"/>	Date	<input type="text"/>

### 4. Entry of data from this form into Themis Themis Incident Report confirmation number:

Entered into Themis by (name):  Date

### 5. Immediate Response — Supervisor to complete (not required if Sections 1-3.2 have been entered into Themis)

Treatment given to injured person by: Nil  First aider  General practitioner  Hospital (Casualty)  Hospital (In-patient)

Did any University employee injured as a result of the incident take time off work? No  Yes  --> *If Yes, inform University WorkCover office*

Immediate actions taken to prevent or reduce risk of re-occurrence

<sup>1</sup> Elimination Control  <sup>2</sup> Substitution Control  <sup>3</sup> Engineering Control  <sup>4</sup> Administrative Control  <sup>5</sup> Personal Protective Equipment

Detail the actions

• Supervisor must use an Incident Investigation (S4) form to assess the level of risk and establish planned/permanent corrective actions.

Name of supervisor	<input type="text"/>	Date	<input type="text"/>
Signature of supervisor	<input type="text"/>	Date	<input type="text"/>