

INCIDENT REPORT FORM

File ref: IFM35/79028

Version: 2.0

Issue date: March 2022

INCIDENT REPORT FORM

This incident report form is an initial notification of incident or injury and must be completed in consultation with the Shift supervisor and/or a KPA Manager. A statement may be transcribed on behalf of the person involved or witness. All statements must be factual in recollection. This form is to be acknowledged by the Department Manager and managed by the HSER Department.

Depending on the nature of the incident or injury a more comprehensive report and investigation may be required.

Surname				First Name				
Company				Department				
Signature								
Shift Start Time		Shift End Time		Supervisor				
Directly Involved			Witness					
Exact Location of Incident								
Date and Time of Incident								
Task being Completed								
Date and Time of Statement								
Equipment DIRECTLY involved in the incident								
Incident Summary – include events from beginning of shift to after incident had occurred including people involved, communications, work being conducted, equipment involved, environmental conditions and any other factors for consideration								



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Persons Involved – Directly or Indirectly	
Person, Position and Employer	Involvement
	(e.g. Injured Person, Witness, First Aider)
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	That Alder)
List any work method tasks were being conducted under (work perretc.)	



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Diagram of Inci	dent				
Department Ma	nager Acknowled	dgement			
Name				Date	
Signature					
Causal DAS co	mpleted	☐ Yes	☐ No		