TRC GROUP ACCIDENT AND HAZARD REPORT FORM

Issue Date: **Version Number:** 1 **Page Number:** 1

Details of Affected Person or Near Miss (This form incorporates a register of injuries)

Nature of Incident:

TRC Group to Complete:
Circle the appropriate type: *Employee* *Contractor*

Name:		Position:	
Address:		Site Address:	
Contact Tel:		Client Name:	
Mobile Tel:			

Accident / Near Miss / Hazard Details

Employee or Contractor to complete, TRC Group representative to assist where required):

Describe exact site location:	

Describe sequence of events leading to Incident or details of hazard:

Injury Details

Employee or contractor to complete TRC Group representative to assist where required):

Nature of Injury

❒ Sprain / Strain	❒ Bruising	❒ Concussion	❒ Open Wound
❒ Fracture	❒ Dislocation	❒ Burns / Scold	❒ Exposure to Elements
❒ Exposure to substance	❒ Skin rash	❒ Respiratory Irritation	❒ Hearing Loss
❒ Pain / Tenderness	❒ Whip lash	❒ Crush Injury	❒ Swelling
❒ Other (Specify):			

Part of body Injured			
Part of Body	**Side of body**	**Region**	**Internal or External**
❒ Head	❒ Left ❒ Right	❒ Back ❒ Front	❒ Internal ❒ External
❒ Face	❒ Left ❒ Right	❒ Nose ❒ Mouth ❒ Jaw	❒ Internal ❒ External
❒ Eye	❒ Left ❒ Right	Sighted Affected Y❒ N❒	❒ Internal ❒ External
❒ Torso	❒ Left ❒ Right	❒ Upper ❒ Lower	❒ Internal ❒ External
❒ Back	❒ Left ❒ Right	❒ Upper ❒ Lower	❒ Internal ❒ External
❒ Arm	❒ Left ❒ Right	❒ Upper ❒ Lower	❒ Internal ❒ External
❒ Hand	❒ Left ❒ Right	❒ Upper ❒ Lower	❒ Internal ❒ External
❒ Leg	❒ Left ❒ Right	❒ Upper ❒ Lower	❒ Internal ❒ External
❒ Foot	❒ Left ❒ Right	❒ Upper ❒ Lower	❒ Internal ❒ External
❒ Other*	❒ Left ❒ Right	❒ Upper ❒ Lower	❒ Internal ❒ External

*Other – Please describe

Treatment Details: Circle the type of action undertaken:

No treatment *First Aid* *Medical Treatment* *Hospitalisation*

Outline specific action undertaken:	
Did you return to work after treatment?:	**Y ❒ N ❒**

Sign off by Employee/contractor (Where Possible)	
Name:	**Date:**
Position:	**Signature:**
Preventative Action (TRC Group to complete):	
Director to Complete:	
Action taken to prevent recurrence of incident (Control Measures):	
Return to Work	
Alternative duties / tasks available:	
Client Incident Report form received: Y ❒ N ❒	**Date:**
Incident events confirmed with client: Y ❒ N ❒	**Candidate Code:**
Name of Client Representative (where relevant):	**Candidate D.O.B:**
Date Accident Incident Report Received:	
Workers Compensation Regulator Notification Required Y ❒ N ❒	
Sign off by TRC Group Director:	
Name:	**Date:**
Position:	**Signature:**