

INCIDENT REPORT

PLEASE USE BLOCK LETTERS | ALL SECTIONS MUST BE COMPLETED

Club:			
Date Reported:		Time Reported:	
Exact Location:			
Date of Incident:		Time of Incident:	
		Day Of Week:	
Incident Report Completed By:		Incident Reported To:	
Time Incident Location Inspected:		Inspected By:	

PART 1 – INJURED PERSON DETAILS

Name:	Surname			Given Names		
Address:						
		State:		Post Code:		
Telephone (AH):			Telephone (BH):			
Mobile:						
Date of Birth:	(Approx. or guess if unknown)		Sex:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Walking Stick <input type="checkbox"/>	Glasses <input type="checkbox"/>	Carrying Goods <input type="checkbox"/>	Intoxicated <input type="checkbox"/>	Other Impairments <input type="checkbox"/>		

PART 2 – WITNESS DETAILS * (*Eyewitness who witnessed the incident; circumstantial witness who witnessed the events leading up to or following the incident. Additional witnesses' details should be provided on attachment)

Attach Statements for Additional Comments						
Name of Witness to accident:	Surname			Given Names		
Address of Witness to Accident:						
		State:		Post Code:		
Telephone (AH):			Telephone (BH):			
Mobile:						
Type of Witness:	Eye Witness <input type="checkbox"/>		Circumstantial Witness <input type="checkbox"/>			
Relationship to Injured Person:						
(If more than one witness, please provide details)						

PART 2 – WITNESS DETAILS (continued)

If another party responsible please provide details

PART 3 – PERSONAL INJURY DETAILS

Part Of Body Injured (Place tick in appropriate box)

Address:

Head & Neck	<input type="checkbox"/>	Hip	<input type="checkbox"/>	Hands/Fingers	<input type="checkbox"/>
Eyes or Face	<input type="checkbox"/>	Shoulder	<input type="checkbox"/>	Knee	<input type="checkbox"/>
Back & Trunk	<input type="checkbox"/>	Arms/Wrists	<input type="checkbox"/>	Feet	<input type="checkbox"/>

If Other, or multiple, please describe

Nature of Injury (Place tick in appropriate box)

Multiple	<input type="checkbox"/>	Minor Bruise – Not Disabling	<input type="checkbox"/>	Concussion/Unconscious (Serious)	<input type="checkbox"/>
Fracture	<input type="checkbox"/>	Major Bruising – Disabling	<input type="checkbox"/>	Burns/Scalds – requiring medical attention	<input type="checkbox"/>
Sprain	<input type="checkbox"/>	Minor Cut/Laceration – No Stitches	<input type="checkbox"/>	Superficial	<input type="checkbox"/>
Dislocation	<input type="checkbox"/>	Cut/Laceration requiring Stitches	<input type="checkbox"/>	No Apparent Injury	<input type="checkbox"/>
		Ligament Damage	<input type="checkbox"/>	Minor Concussion	<input type="checkbox"/>

If Other, describe

Description of and sequence of events leading up to the incident (as described by injured party)

Description of Incident (by you or independent witness – including an un-biased view on whether the injured person contributed to the injury)

Was Injured person taken to

Treatment by First Aider	<input type="checkbox"/>	Doctor/Hospital	<input type="checkbox"/>	Ambulance	<input type="checkbox"/>
Name of first aider/person attending:			Contact Number:		
Other (please describe):					

PART 3 – PERSONAL INJURY DETAILS (Continued)

If Third Party/Contractor at fault		
Third Party/Contractor Name:		
Third Party/Contractor's Insurance Details:		

PART 4 – PROPERTY DAMAGE (complete if there is property damage)

Item Damaged:	
Details:	
If viewed and by whom:	
Photos taken and by whom:	

PART 5 – LOCATION OF INCIDENT (please tick in appropriate boxes)

Car Park <input type="checkbox"/>	Entrance/Exit <input type="checkbox"/>	Stairs <input type="checkbox"/>
Court/Playing Surface <input type="checkbox"/>	Office Areas <input type="checkbox"/>	Escalators <input type="checkbox"/>
Bar <input type="checkbox"/>	Internal Ramp <input type="checkbox"/>	Toilet Areas <input type="checkbox"/>
Gym Floor <input type="checkbox"/>	Children's Play Area <input type="checkbox"/>	Restaurants <input type="checkbox"/>
Food Areas <input type="checkbox"/>	Balcony <input type="checkbox"/>	Gaming Areas <input type="checkbox"/>
Dance Floor <input type="checkbox"/>		
If other please describe		

PART 6 – TYPE OF INCIDENT (please tick in appropriate boxes)

Slip and Fall of Person: Cause		
Chips <input type="checkbox"/>	Lack of Barrier <input type="checkbox"/>	Uneven Floor <input type="checkbox"/>
Ice Cream <input type="checkbox"/>	Rainwater on floor <input type="checkbox"/>	Tripped over Object <input type="checkbox"/>
Beverage <input type="checkbox"/>	Barrier/Signs <input type="checkbox"/>	Steps/Stairs <input type="checkbox"/>
Floor Slippery (Surface) <input type="checkbox"/>	Vegetable/Fruit items <input type="checkbox"/>	Car Park Stops/Bollards <input type="checkbox"/>
Inadequate Lighting <input type="checkbox"/>	Other Food <input type="checkbox"/>	No Apparent Reason <input type="checkbox"/>
Person Running <input type="checkbox"/>	Vomit <input type="checkbox"/>	
If other please describe		
Or Caught In		
Door <input type="checkbox"/>	Escalator/Elevator <input type="checkbox"/>	Machinery <input type="checkbox"/>
Other <input type="checkbox"/>		
If other please describe:		
Stepping on or Striking Against:		
Display Stands <input type="checkbox"/>	Escalator/Elevator <input type="checkbox"/>	Other <input type="checkbox"/>
Sharp Edges/Protruding Objects <input type="checkbox"/>	Doors <input type="checkbox"/>	

PART 6 – TYPE OF INCIDENT (please tick in appropriate boxes) (continued)

If other please describe:			
Other			
Door	<input type="checkbox"/>	If Falling Objects, please describe:	
Water Damage	<input type="checkbox"/>		
Type of Surface			
Marble	<input type="checkbox"/>	Tile	<input type="checkbox"/>
		Carpet	<input type="checkbox"/>
		Speed hump	<input type="checkbox"/>
Terrazzo	<input type="checkbox"/>	Timber	<input type="checkbox"/>
		Bitumen	<input type="checkbox"/>
		Dirt/Grass/Garden	<input type="checkbox"/>
Slate	<input type="checkbox"/>	Vinyl	<input type="checkbox"/>
		Concrete	<input type="checkbox"/>
		Other	<input type="checkbox"/>
If other please describe:			
Was Injured Person			
Reasonable	<input type="checkbox"/>	Upset	<input type="checkbox"/>
		Aggressive	<input type="checkbox"/>
		Add Relevant Comments	
Cleaner on Duty:		Cleaning Supervisor:	
Time Location Last Inspected:		Time Last Cleaned:	
Please attach written statement from Cleaner (if appropriate)			
Record of Incident			
Video/closed circuit	<input type="checkbox"/>	Photo	<input type="checkbox"/>
		None	<input type="checkbox"/>

Signature:	
Name:	
Date:	



PLEASE EMAIL YOUR COMPLETED FORM TO YOUR MSA BRANCH

MSNSW: admin@mastersswimmingnsw.org.au
 MSNT: msnt@iinet.net.au
 MSQ: admin@mastersswimmingqld.org.au
 MSSA: mssasecretary@adam.com.au
 MST: mastersswimmingtasmania@gmail.com
 MSV: admin@mastersswimmingvic.org.au
 MSWA: masters.admin@mswa.asn.au
 FOR POSTAL ADDRESSES VISIT:

<https://mastersswimming.org.au/about/branches-and-affiliated-clubs/>