ATTACHMENT A

IN-CONFIDENCE

FIRST AID FORM

INFORMATION ABOUT PERSON BEING TREATED		
Personal details:		
Name:	Date of Birth:	Sex: Female / Male
Address:		
Home Telephone:	Business Telephone:	
Known illness, including medications:		
Office Unit:		
Position:		
Incident/Accident details:		
Date:	Time:	
Work processes being performed:		
Description of incident/accident:		
Injury/Illness details:		
First Aid treatment provided:		
Date:	Time:	
Details:		
Referral (for further treatment, e.g. ambulance, hospital, doctor):		
Subsequent Injury/Illness Management (e.g. details of rehabilitation etc):		
FIRST AID PROVIDED BY:		
Name: (person completing this form)		
Position:		
Signature:		

ATTACHMENT B

Office of the Information Commissioner
Queensland

INCIDENT NOTIFICATION FORM

Details of Person Involved/Injured

Employment Status: ☐ Office of the Information Commissioner employee ☐ Contractor
☐ Member of the public ☐ Other (Please Specify)_____

Given Names: _____ Surname: _____

Address: _____

Contact Telephone Number: _____ Mobile: _____

Date of Birth: ____ / _____ / _____ Occupation: _____

Description of Incident

Date of Incident: ___ / ___ / ___ Time: _____ am/pm Date Reported: ___ / ___ / ___

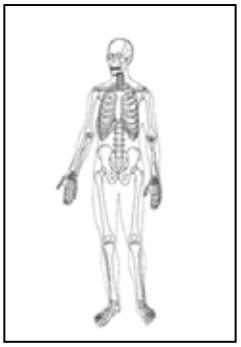
Incident Reported to: _____ Designation: _____

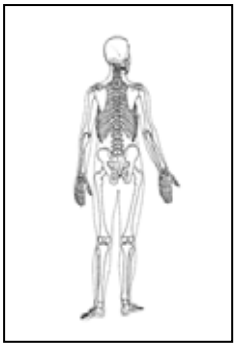
What were you doing at the time of the incident? _____
_____

Where were you when the incident occurred? _____
_____

What happened to cause the incident? _____
_____

Other factors involved:
☐ Falls, trips and slips ☐ Sound and pressure ☐ Biological factors ☐ Hitting objects with part of body
☐ Body stressing ☐ Mental stress ☐ Heat radiation and electricity ☐ Chemicals and other substances
☐ Other and unspecified factors: _____





← **PLEASE INDICATE INJURY LOCATION**

Type of Injury: ☐ Sprain & Strain
☐ Fracture ☐ Cut ☐ Electric Shock
☐ Burns ☐ Bruising

Bodily Location of Injury: _____
_____
_____

Medical Treatment: ☐ nil ☐ first aid
☐ doctor ☐ hospital

Hospital admitted to : _____

Other items involved: ☐ Machinery and (mainly) fixed plant ☐ Mobile plant and transport ☐ Biological agencies
☐ Power equipment, tools and appliances ☐ Non-powered tools and equipment ☐ Environmental agencies
☐ Chemicals and chemical products ☐ Materials and substances
☐ Other and unspecified agencies: _____

Names and contact details of witnesses: _____
_____

Signature of Person involved/injured: _____ _____ / _____ / _____

Incident Type

Office Use Only: MCES Received _____ / _____ / _____ PS Incident Report No. _____
Type of incident ☐ Work injury ☐ Serious bodily injury ☐ Work caused illness ☐ Dangerous Event
☐ Dangerous electrical event ☐ Yes ☐ No Serious electrical incident, has the area been made safe?
☐ Yes ☐ No Was injury/illness fatal? ☐ Yes ☐ No Notify Department of Industrial Relations?

Name of Investigating WHSO: _____ Telephone Number: _____