

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"/>		Hitting <input type="checkbox"/>
Contact with <input type="checkbox"/>			Muscular stress from <input type="checkbox"/>	
Exposure to <input type="checkbox"/>			Trapped between <input type="checkbox"/>	
Fall from <input type="checkbox"/>			Trapped by <input type="checkbox"/>	
Hit by <input type="checkbox"/>			Vehicle Accident <input type="checkbox"/>	
Other (specify)				

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 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 Injury Management office*

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

1 Elimination Control 2 Substitution Control 3 Engineering Control 4 Administrative Control 5 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"/>
Signature of supervisor	<input type="text"/>
Date	<input type="text"/>