



# Report Form

Office Registration

Report No.: .....
Date Received: .....
Received By: .....

## Report Type (Please tick one or more of the following)

<input type="checkbox"/> Incident	<input type="checkbox"/> Action Required	<input type="checkbox"/> Client Feedback	<input type="checkbox"/> Other – Specify:
<input type="checkbox"/> Hazard	<input type="checkbox"/> Information Only	<input type="checkbox"/> Improvement	.....

## Report Details (Please describe what you wish to report)

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## Relevant Information (Please complete those sections applicable to your report)

Date: .....			Time: .....			Location: .....		
<b>Client Details:</b>				<b>Others Involved / Witnesses:</b>				
Full Name: .....				Full Names:				
Address: .....				1. ....				
.....				2. ....				
<b>Risks:</b>			<b>Consequences if Occurring:</b>		<b>Likelihood of Occurring:</b>			
1. ....			.....		.....			
2. ....			.....		.....			

## Action Taken / Recommended (Please describe the actions you have, or wish to see, taken)

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## Reported By

Full Name: .....	Date: .....
Position: .....	Signed: .....

Please submit your report to the office as soon as possible. If you require more space please attach further page(s).

## Office Follow Up

### Recipient's Report (Please detail any further information or actions taken since receiving report)

See attachments (list): \_\_\_\_\_

See further information at: \_\_\_\_\_

Name: \_\_\_\_\_ Position: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

### Supervisor's Endorsement

Risk Level (please circle): \_\_\_\_\_ Negligible    Low    Medium    High    Extreme

Any mandatory reporting requirements?     No     Yes – Specify: \_\_\_\_\_

Further action required?     No     Yes – Responsibility for action plan: \_\_\_\_\_

Comment: \_\_\_\_\_

Name: \_\_\_\_\_ Position: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

### Action Plan

No	Action Required	By Whom	By When	Initial	Outcome	Date	Initial

### Preventative Action Report (Please complete if further, or ongoing, action is required)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Summary of Outcome

\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_ Position: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

### Supervisor's Closure

Final destination of original report:     Client File     OH&S Committee     Other Specify: \_\_\_\_\_  
    Staff File        Management Review    \_\_\_\_\_

Copies made / released to: \_\_\_\_\_

Comment: \_\_\_\_\_

Name: \_\_\_\_\_ Position: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_