

Critical Incident Form

ALL INCIDENTS MUST BE REPORTED

- Please PRINT all details. If there is insufficient space please attach additional information, sketches etc.
- This report must be completed, **signed** and emailed to within **24 hours** of an accident/ incident or near miss occurring compliance@dellainternational.edu.au
- Forward the **original** to 150-154 A'Beckett Street Melbourne 3000
- **STAFF ONLY** - If lodging a **Workers' Compensation Claim** you must contact the admin staff at Della for a Workers' Compensation Claim Form to be given to the worker's nominated treating doctor to obtain a WorkCover Medical Certificate.
- **STUDENTS ONLY** – Please completed the form and full detail if additional information is required you will be contacted by a Student Support Officer.
- **FOR ALL** other incidents please complete the section of the report with as much detail as available.
- This report is **CONFIDENTIAL** and information provided is protected by the Privacy and Data Protection Act 2014 (VIC), and the Health Records Act 2001 (VIC).

Details of injured person are to be completed by person/ first aid officer/ witness

First Name: Last Name:

Residential Address:

Is person: Staff Student Visitor Gender: Male Female

Date of Birth: Position:

Telephone: Home Employment Status: Full Time Part Time Casual

No of hours worked on the day of injury: _____

Date Occurred: Time Occurred: am/pm Location:

Nature of Incident (*eg laceration, sprain, near miss, vehicle accident*):
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.....

Area of Damage/Part of Body Injured (*eg none, right leg, crumpled car bumper*):
.....
.....

State exactly how incident occurred:
.....
.....

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Returned to Work/Study		First Aid		Attended Doctor		Attended Hospital	
Yes	No	Yes	No	Yes	No	Yes	No
If No - Date Stopped		Name of Officer		Name of Doctor		Name of Hospital	

Details of Treatment: (e.g. ice applied):
 (Should the illness/ injury worsen please forward an updated Accident/ Incident Report Form)

Witness/s: Name
 Address

Details of Hazards:

Investigation of Incident:

For Investigation purposes and to help to prevent similar occurrences in the future, do you consent to **Della's** designated Representative being provided with a copy of this accident report? Yes No

Please sketch the incident scene (marking your location, the location of the student or staff member injured, any furniture/objects or other students present at that time) in the box below.

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Where the incident does not relate to a physical incident please provide the nature of the incident and details of how it was managed, if additional space is required please use a separate page:

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Is a risk assessment needed? Yes No

Outcomes of this incident:

.....
.....
.....
.....
.....

****Notifiable incidents involving a fatality or a serious injury or illness***

1. **Incidents involving a fatality or a serious injury or illness:**
 - Call WorkCover immediately on 13 26 60 as an urgent investigation may be needed, or
2. **Incidents involving a fatality or serious injury or illness to a person not covered by your workers' compensation insurance such as a visitor, customer, volunteer, student or contractor for example:**
 - Call WorkCover immediately on 13 26 60 as an urgent investigation may be needed.
3. **Data Breaches must be assessed in consultation with the Records Retention Policy and Procedure.**

.....
Person Completing Report (print name)

.....
Signature

.....
Date