

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?	<i>Select the action</i>	<i>Specify the object</i>	<i>Select the action</i>	<i>Specify the object</i>
	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)			

For example:

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

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 1-3.2 have been entered into Themis)

Treatment given to injured person by: Nil First aider General practitioner Hospital (Casualty) Hospital (In-patient)

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"/>