PHYSIO BY DESIGN
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Incident Report Form

Name of person reporting incident: _____

Name of person/s involved with the incident: _____

Time: _____ Date: __/__/__ Place of incident: _____

What is the incident? include the impact on, or harm caused to, any person with or without disability affected by the incident;

_____
_____
_____

Has any short-term measure been taken to resolve the incident? – describe: (include action taken to support or assist persons with disability affected by the incident):

_____
_____
_____

What further action is required?

_____
_____
_____

Signed: _____ Date: __/__/__
Name: _____ Contact details: _____

Signed: _____ Date: __/__/__
Witness: _____ Contact details: _____

Signed: _____ Date: __/__/__
Witness: _____ Contact details: _____

Completed by manager:

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Action taken to rectify problem:

_____

_____

_____

Action completed by: Date: __/__/__

Further action needed to be undertaken to prevent further similar incidents from occurring, or to minimise their impact:

_____

_____

_____

Action completed by: Date: __/__/__

How well was the incident managed and resolved?:

_____

_____

_____

Were any consultations undertaken with persons with a disability affected by the incident?

_____

_____

_____

Managers Signature: _____ Date: __/__/__

Copy of form returned to person(s) raising issue: Yes □

Could the incident have been prevented: Yes □ No □

If needed
- Reported to the Commissioner: Yes □ No □ Date: __/__/__
- Reported to Work Cover: Yes □ No □ Date: __/__/__
- Reported to Other: Yes □ No □ Date: __/__/__

Were any persons with disability affected by the incident? Have they been provided with any reports or findings regarding the incident? Yes □ No □ Date: __/__/__

Monitoring that control measure was effective: Yes □ Date: __/__/__

Is an investigation to be undertaken by Physio by Design in relation to the incident?
List the details and outcomes of the investigation: Yes □ No □ Date: __/__/__

_____

_____

_____

_____