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| **Missions Interlink****Incident Report** | |
| A record of injuries and incidents must be provided to the relevant MI Team Leader or Manager WITHIN THREE DAYS of the incident. | |
| Part A – Personal details *(To be completed by person injured/involved in incident or their agent)* | |
| Last name: | First name: |
| Position: |  |
| Telephone no.: |  |
| Part B – Incident details *(To be completed by person injured/involved in incident or their support person)* | |
| Date of incident: | Time of incident: am/pm |
| Date reported: | Time reported: am/pm |
| Location of incident: | |
| Description of incident (including a list of preceding events): | |
| Nature of Incident | |
| Type of incident (injury, damage etc): | |
| Details of incident (including sequence of events prior to the incident): | |
| Cause of incident: | |
| Signature of injured person: Date:  *(If available)* | |
| Part C – Outcome of incident *(To be completed by Team Leader or Manager)* | |
| Description of incident: | |
| Description of first response or first aid treatment given: | |
| First response or first aid provided by: | |
| Further actions taken: | |
| Any ongoing treatment required: | |
| Witnesses where appropriate (name, position, phone contact): | |

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| Part D – INVESTIGATION *(To be completed by Team Leader or Manager)* | |
| What were the key factors contributing to the incident? | |
| Outline any corrective action to prevent recurrence: | |
| Person responsible for corrective action: | |
| Other actions recommended: | |
| Action Completion Date: | |
| Any other details: | |
| **Reported to:** | Name: Date: |
| Signature: |
| Position/Role: |

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| **Work Injury/Incident Report (Page 2)** | | | |
| **Witnesses** *(where appropriate)* | | | |
| Witness 1 | Last name: | | First name: |
| Address: | | Contact No.: |
| **Witness 2** | Last name: | | First name: |
| Address: | | Contact No.: |
| Part D – Incident investigation details *(To be completed by Manager)* | | | |
| What were the key factors contributing to the incident? | | | |
| Outline action/s taken to prevent recurrence: | | | |
| What further action is recommended? | | | |
| Action completed: *(Please tick relevant box)* 🞎 Yes 🞎 No | | | |
| Anticipated completion date: | | | |
| Person accountable for action recommendations: | | | |
| Approval signature | | | |
| National Director Signature*:* | | Date: | |