INSIGHT ACADEMY
make it real

Level 1, 209 Lonsdale Street, Melbourne, VIC 3000, Australia
startup@insightacademy.edu.au
www.insightacademy.edu.au

RTO: 41393 CRICOS: 03467G ABN: 53 600 410 419

INCIDENT REPORT FORM

Section 1 –Details of Person immediately affected by incident			
Full Name:			
Contact Telephone:		**Mobile:**	
Address:			
Email:			
Section 2 – Details of Incident			
Date of Incident:		**Time:**	___ ___ :___ ___ am/pm
Location of Incident:			
Reported to:		**Position Title:**	
Section 3 – Details of Incident and Treatment			
Description of incident:			
How this occurred?			

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Action Provided:
☐ None Required ☐ First Aid (please describe) ☐ Taken to Doctors Surgery (provide detail) ☐ Taken to Hospital (provide detail) ☐ Ambulance called and attended (provide detail) ☐ Other (please describe)
Further Action Recommended:
☐ None ☐ Counselling ☐ External financial counselling ☐ Academic support ☐ Other (please describe)

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Section 4 – Witnesses to Incident			
The following persons witnessed the incident:			
Name 1:		**Contact:**	
Address:			
Signature 1:		**Date:**	/ /
Name 2:		**Contact:**	
Address:			
Signature 2:		**Date:**	/ /

Section 5 – Signatures			
Supervisor:			
Signed:		**Position:**	
Print Name:		**Date:**	
First Aider:			
Signed:		**Position:**	
Print Name:		**Date:**	
Director:			
Signed:		**Position:**	
Print Name:		**Date:**	

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Admin Use Only				
Reported to Insurer:	☐ Yes	☐ No	**Date:**	/ /
Reported By:			**Signature:**	
Reported to Work Safe:	☐ Yes	☐ No	**Date:**	/ /
Reported By:			**Signature:**	
Comments:				