



### COMPLETING THIS FORM

Report all workplace injuries and illnesses to your manager / supervisor immediately.

Submit this form within 48 hours.

### SECTION 1 – INJURED PERSON’S DETAILS

<b>Membership type at time of the injury or illness (select one)</b>	Volunteer Employee – full-time	Junior / Cadet member Employee – part-time	Other agency Employee – temp	Member of public Contractor
First name			Last name	
Gender (M / F)			D.O.B.	
Telephone (work)			Contact No.	
Address (home)				
<b>For an injured NSW RFS volunteer member</b>				
Volunteer I.D.		Rank / Position		
Region				
District				
Brigade				
<b>For an injured NSW RFS staff member</b>				
RFS employee no:		Position		
Directorate				
Section				
<b>Complete if injured person is <u>not</u> a NSW RFS member</b>				
Agency name (if applicable)				
Contractor company name (if applicable)				

### Form Completed By

First name		Position	
Last name		District	
Date completed			

### SECTION 2 – DETAILS OF OCCURRENCE

Date		Time (24hr)	
Time when shift commenced			
Location when injury occurred			
GPS co-ordinates (if known)			
Name of Incident / Fire (if applicable)		Major Incident / S44 Declaration:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Is the occurrence a SafeWork NSW Notifiable Incident?</b>			<input type="checkbox"/> Yes <input type="checkbox"/> No

**Type of occurrence**    Injury    Exposure (eg asbestos, chemical)    Vehicle accident (also complete *Report of Health & Safety Near Miss or Property Damage*)

### Activity Being Performed (select one)

<input type="checkbox"/> Administration / meeting	<input type="checkbox"/> Design activity	<input type="checkbox"/> Mitigation activity	<input type="checkbox"/> Travel (operational)
<input type="checkbox"/> AIDER program	<input type="checkbox"/> Exercises / competitions	<input type="checkbox"/> Planned inspection / audit	<input type="checkbox"/> Travel from work
<input type="checkbox"/> Assisting another agency	<input type="checkbox"/> Fire / incident operations	<input type="checkbox"/> Training (classroom)	<input type="checkbox"/> Travel to work
<input type="checkbox"/> Aviation	<input type="checkbox"/> Hazard reduction	<input type="checkbox"/> Training (field-based)	<input type="checkbox"/> Work break
<input type="checkbox"/> Community activity	<input type="checkbox"/> Maintenance	<input type="checkbox"/> Travel (non-operational)	
<input type="checkbox"/> Other (describe)			

Details of the injury and how it occurred (attach additional information as required)

What has been done (so far) to prevent further injury or illness, and by whom?



# NSW Rural Fire Service

## REPORT OF WORKPLACE INJURY OR ILLNESS

### SECTION 3 – INJURY CATEGORY

#### Bodily Location of Injury (select all that apply)

- |                               |                                  |  |                                    |
|-------------------------------|----------------------------------|--|------------------------------------|
| <input type="checkbox"/> Arms | <input type="checkbox"/> Face    | <input type="checkbox"/> Head            | <input type="checkbox"/> Neck      |
| <input type="checkbox"/> Back | <input type="checkbox"/> Feet    | <input type="checkbox"/> Hips            | <input type="checkbox"/> Shoulders |
| <input type="checkbox"/> Ear  | <input type="checkbox"/> Fingers | <input type="checkbox"/> Internal organs | <input type="checkbox"/> Trunk     |
| <input type="checkbox"/> Eye  | <input type="checkbox"/> Hands   | <input type="checkbox"/> Legs            | <input type="checkbox"/> Toes      |

#### Nature of Injury (select one)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Amputation / de-gloving | <input type="checkbox"/> Fracture                  | <input type="checkbox"/> Poisoning / toxic effect |
| <input type="checkbox"/> Breathing difficulties  | <input type="checkbox"/> Head injury               | <input type="checkbox"/> Psychological Injury     |
| <input type="checkbox"/> Burns                   | <input type="checkbox"/> Heart attack              | <input type="checkbox"/> Smoke inhalation         |
| <input type="checkbox"/> Contusion / crush       | <input type="checkbox"/> Heat stress / heat stroke | <input type="checkbox"/> Spinal injury            |
| <input type="checkbox"/> Dislocation             | <input type="checkbox"/> Internal injury           | <input type="checkbox"/> Sprains / strains        |
| <input type="checkbox"/> Foreign body            | <input type="checkbox"/> Laceration / abrasion     |   |
| <input type="checkbox"/> Other (describe)        |  |   |

#### Mechanism of Injury (select one)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Animals / insects           | <input type="checkbox"/> Falls from a height        | <input type="checkbox"/> Psychological factors |
| <input type="checkbox"/> Being hit by moving objects | <input type="checkbox"/> Fatigue                    | <input type="checkbox"/> Radiation             |
| <input type="checkbox"/> Body fluids / hygiene       | <input type="checkbox"/> Fire over-run              | <input type="checkbox"/> Repetitive movement   |
| <input type="checkbox"/> Chemicals or substances     | <input type="checkbox"/> Ground collapse / cave-in  | <input type="checkbox"/> Slip / trip           |
| <input type="checkbox"/> Electricity                 | <input type="checkbox"/> Hitting stationary objects | <input type="checkbox"/> Smoke                 |
| <input type="checkbox"/> Environmental conditions    | <input type="checkbox"/> Noise                      | <input type="checkbox"/> Vehicle accident      |
| <input type="checkbox"/> Exposure to heat or cold    | <input type="checkbox"/> Other muscular stress      | <input type="checkbox"/> Vibration             |
| <input type="checkbox"/> Falling trees / branches    | <input type="checkbox"/> Pressurised air / liquid   |  |
| <input type="checkbox"/> Other (describe)            |   |  |

### SECTION 4 – TREATMENT / SEVERITY DETAILS

**Treatment provided**     No treatment     First aid     Doctor or other medical practitioner  
 Ambulance     Hospital (emergency / outpatient)     Hospital (admitted / inpatient)

Treatment provided at (Facility) \_\_\_\_\_  
 Treatment provided by (Name) \_\_\_\_\_

Is the injury expected to result in a Workers Compensation claim?     Yes     No  
 Did the injury result in time away from work?     Yes     No  
 If yes, did it result in time away from work only on the day / shift when the injury occurred?     Yes     No

Date work ceased \_\_\_\_\_ Time work ceased (24 hr) \_\_\_\_\_

### SECTION 5 – NSW RFS MANAGER'S COMMENTS (to be completed by a salaried manager of the NSW RFS)

**Could a more severe injury have resulted from this incident? If yes, how severe do you think the injury could have been?**  
 (select one)     Minor Injury (no treatment or first aid)     Medical or Hospital Treatment     Permanent Disability or Fatal Injury

**Further comments**

\_\_\_\_\_

**NSW RFS Manager Sign-off**

<b>Name</b>	_____	<b>Telephone</b>	_____
<b>Position</b>	_____	<b>Date</b>	_____
<b>Signature</b>	_____		

### SECTION 6 – INSTRUCTION AND INFORMATION

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>This Form is to be treated as confidential.</li> <li>Assistance in completing this form can be obtained from your District Office, or via the Health &amp; Safety Hotline ph 02 8741 5221 during normal business hours.</li> <li>Completed Form to be retained by Manager.</li> </ul> | <p><b>NSW RFS Manager to submit a copy of Form to the following:</b></p> <ul style="list-style-type: none"> <li>State Operations via email <a href="mailto:state.ops@rfs.nsw.gov.au">state.ops@rfs.nsw.gov.au</a></li> <li>Health &amp; Safety via email <a href="mailto:safety@rfs.nsw.gov.au">safety@rfs.nsw.gov.au</a></li> </ul> |
|--|--|

### HEALTH, SAFETY & WELFARE USE ONLY

<b>Date received</b>		<b>Investigation level</b>	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<b>Claim no.</b>	
<b>Date entered</b>		<b>Investigation requested</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No    Date: _____	<b>Lodged by</b>	
<b>Ref no.</b>		<b>Claim lodged?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Date lodged</b>	