**Attachment 1**

**Register of**

* **Injuries**
* **Illness**
* **Near Miss**
* **Hazard**

**Folder**

**Shine Bright EYM Requirements regarding OH&S**

At each regular local staff meeting, OH&S is to be an agenda item.

Staff are to review their **Register of Injuries/Illness/Near Miss/Hazard forms** kept in the **Register of Injuries/Illness/Near Miss/Hazard Folder**

If a hazard is identified a risk assessment and control checklist should be completed. (Please see **Safety at work,** A guide for kindergartens - Appendix 4)

A soft copy of this form is to be kept on your service computer desktop.

**Register of Injuries/Illness/Near Miss/Hazard**

**Section 1: My Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Family name:** |  | **First name:** |  |
| **Position:** |  | **Service Name:** |  |
| **Nominated Supervisor:**  |  |
| **Early Years Advisor** |  |

**Section 2: Tick One**

|  |  |  |
| --- | --- | --- |
| **My Incident/Illness:**An injury occurred [ ]  | **My Near Miss:**While performing a task but had no injury [ ]   | **My Hazard Report**Task or object that could cause an injury [ ]  |
| **Date Reported:** |  |
| **Is this a Victorian WorkSafe Authority reportable Incident?** Yes[ ] No[ ] *A reportable incident is one of the following: OH&S Act 2004*37(1) the death of a person, a person requiring medical treatment within 48 hours of exposure to a substance, a person requiring immediate medical treatment as an in-patient(admitted) in a hospital, a person requiring immediate medical treatment for the amputation of any part of his/her body or a serious head injury or a serious eye injury or the separation of his or her skin from an underlying tissue(such as de-gloving or scalping) or electric shock or spinal injury or the loss of a bodily function or serious laceration.**Report Phone Line: 13 23 60** |

**Section 2: Injury/Illness/Near Miss/Hazard details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date:** |  | **Time of injury/near miss:**  |  | am/pm  |
| **Nature of injury/illness/near miss or description of hazard** |
|  |
| **Bodily location of injury/illness** |
|  |
| **Exact location at time of injury/illness/near miss or description of hazard** |
|  |
| **Describe how the injury/illness/near miss or hazard was sustained/identified** |
|  |
| **Was any equipment involved?**  | Yes / No (Please select or circle your response) |
| *If yes, please provide details:* |
|  |

**Section 3: Witnesses**

|  |  |
| --- | --- |
| **Were there any witnesses?**  | Yes / No (Please select or circle your response) |
| *If yes, please list the witnesses’ full names as well as a contact number for each.* |
|  |

**Section 4: Follow up**

|  |  |
| --- | --- |
| **Was the incident/hazard reported to the worker’s Responsible Person in Charge?**  | Yes / No (Please select or circle your response) |
| **Was the incident/hazard reported to the worker’s Nominated Supervisor?** | Yes / No (Please select or circle your response) |
| **Was the incident/hazard reported to the worker’s Early Years Advisor?** | Yes / No (Please select or circle your response) |
| **Was any treatment provided?**  | Yes / No (Please select or circle your response) |
| *If yes, please provide details.* |
|  |
| **Did the injured worker return to work following the injury/illness?**  | Yes / No (Please select or circle your response) |
| *If yes, please provide details.* |
|  |

**Section 5: Details of person making this entry**

|  |  |  |  |
| --- | --- | --- | --- |
| **Family name:** |  | **First name:** |  |
| **Position:** |  | **Department/section:** |  |
| **Signature:** |  | **Date:**  |  |
| **If you are not the injured worker, did you witness the incident/hazard?**  | Yes / No (Please select or circle your response) |

**Section 6: To be completed by Early Years Advisor**

|  |  |
| --- | --- |
| **Has an investigation been conducted into the incident/hazard?** | Yes / No (Please select or circle your response) |
| **What, if any, controls were implemented to ensure the incident/hazard doesn’t happen again?** |
|  |

**Section 7: Employer confirmation**

|  |  |  |
| --- | --- | --- |
| I, |  | (print name), of |
| Shine Bright EYM |  |
| hereby confirm receipt of this notification. |
| Signature: |  | Date: |  |

|  |
| --- |
| **Requirements of injury notification:*** Employers must keep a **Register of Injuries** at each workplace for employees to record any workplace injury or illness. At Shine Bright EYM Workplaces this record will be in a clearly labelled **Register of Injuries/Illness/Near Miss/Hazard** folder to be kept in the office.
* An injured worker (or someone acting on their behalf) must notify the employer in writing of any work-related injury or illness within 48 hours of becoming aware of the injury or illness.
* Employers must provide written confirmation to the injured worker that they received notification of the injury or illness.
* Employers should provide a signed and dated copy of this entry to the injured worker.
* To make a WorkSafe claim the injured worker must complete a *Worker’s Injury Claim Form*, available from the Australia Post.
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