

Public Liability Incident Report Form

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AFSL 240954 ABN 33 006 500 072

INCIDENT REPORT FORM

INSURED: _____

DATE REPORTED: _____ TIME REPORTED: _____

EXACT LOCATION: _____

DATE OF INCIDENT: _____ TIME OF INCIDENT: _____ DAY OF WEEK: _____

INCIDENT REPORT COMPLETED BY _____ INCIDENT REPORTED TO: _____

TIME INCIDENT LOCATION INSPECTED: _____ INSPECTED BY: _____

PART 1: INJURED PERSON DETAILS

NAME: _____
(Surname) (Given Names)

ADDRESS: _____

TELEPHONE NO: (Home) _____ (Business) _____ (Mobile) _____

DATE OF BIRTH: _____ (approx or guess if unknown) MALE ☐ FEMALE ☐

WALKING STICK ☐ GLASSES ☐ CARRYING GOODS ☐ INTOXICATED ☐

OTHER IMPAIRMENTS ☐

PART 2: WITNESS * DETAILS

* Eyewitnesses witnessed the incident; circumstantial witnesses witnessed the events leading up to or following the incident. Additional witnesses' details should be provided on attachment.

ATTACH STATEMENTS FOR ADDITIONAL COMMENTS

NAME OF WITNESS TO ACCIDENT: _____
(Surname) (Given Names)

ADDRESS OF WITNESS: _____

TELEPHONE NO: (Home) _____ (Business) _____ (Mobile) _____

TYPE OF WITNESS: EYE WITNESS ☐ CIRCUMSTANTIAL WITNESS ☐

RELATIONSHIP TO INJURED PERSON: _____

(If more than one witness, please provide details) _____

IF ANOTHER PARTY RESPONSIBLE, PLEASE PROVIDE DETAILS: _____

PART 3: PERSONAL INJURY DETAILS

PART OF BODY INJURED (Place tick in appropriate box)

Head & Neck	<input type="checkbox"/>	Hip	<input type="checkbox"/>	Hands/ Fingers	<input type="checkbox"/>
Eyes or Face	<input type="checkbox"/>	Shoulder	<input type="checkbox"/>	Leg/Knee	<input type="checkbox"/>
Back & Trunk	<input type="checkbox"/>	Arms / Wrists	<input type="checkbox"/>	Feet and toes	<input type="checkbox"/>

If Other, or multiple, please describe: _____

NATURE OF INJURY (Place tick in appropriate box)

Multiple	<input type="checkbox"/>	Minor Bruise - Not Disabling	<input type="checkbox"/>	Concussion/Unconscious (Serious)	<input type="checkbox"/>
Fracture	<input type="checkbox"/>	Major Bruising - Disabling	<input type="checkbox"/>	Burns/Scalds – requiring medical attention	<input type="checkbox"/>
Sprain	<input type="checkbox"/>	Minor Cut/Laceration - No Stitches	<input type="checkbox"/>	Superficial	<input type="checkbox"/>
Dislocation	<input type="checkbox"/>	Cut/Laceration requiring Stitches	<input type="checkbox"/>	No Apparent Injury	<input type="checkbox"/>
Ligament Damage	<input type="checkbox"/>	Minor Concussion	<input type="checkbox"/>		

If Other, describe: _____

DESCRIPTION OF and SEQUENCE OF EVENTS LEADING UP TO THE INCIDENT (as described by injured party)

DESCRIPTION OF INCIDENT (by you or independent witness – including an un-biased view on whether the injured person contributed to the injury)

WAS INJURED PERSON TAKEN TO: TREATMENT BY FIRST AIDER ☐ DOCTOR/HOSPITAL ☐ AMBULANCE ☐

NAME OF FIRST AIDER/ PERSON ATTENDING: CONTACT NO:

☐ OTHER (Please describe):

IF THIRD PARTY/CONTRACTOR AT FAULT: THIRD PARTY/CONTRACTOR'S NAME:

THIRD PARTY/CONTRACTOR'S INSURANCE DETAILS

PART 4: PROPERTY DAMAGE (complete if there is property damage)

ITEM DAMAGED:

DETAILS:

IF VIEWED AND BY WHOM:

PHOTOS TAKEN AND BY WHOM:

PART 5: LOCATION OF INCIDENT (Please tick in appropriate box)

Car Park	<input type="checkbox"/>	Entrance/Exit	<input type="checkbox"/>	Stairs	<input type="checkbox"/>
Car Park Ramps	<input type="checkbox"/>	Office Areas	<input type="checkbox"/>	Escalators	<input type="checkbox"/>
Bar	<input type="checkbox"/>	Internal Ramp	<input type="checkbox"/>	Elevators	<input type="checkbox"/>
Toilet Areas	<input type="checkbox"/>	Children's Play Area	<input type="checkbox"/>	Restaurants	<input type="checkbox"/>
Food areas	<input type="checkbox"/>	Balcony	<input type="checkbox"/>	Gaming areas	<input type="checkbox"/>
Dance Floor	<input type="checkbox"/>				

If Other, describe:

PART 6: TYPE OF INCIDENT (Please tick in appropriate box)

Slip and Fall of Person: Cause

Chips	<input type="checkbox"/>	Lack of Barrier	<input type="checkbox"/>	Uneven Floor	<input type="checkbox"/>
Ice Cream	<input type="checkbox"/>	Rainwater on floor	<input type="checkbox"/>	Tripped over Object	<input type="checkbox"/>
Beverage	<input type="checkbox"/>	Barrier/Signs	<input type="checkbox"/>	Steps/Stairs	<input type="checkbox"/>
Floor Slippery (Surface)	<input type="checkbox"/>	Vegetable/Fruit items	<input type="checkbox"/>	Car Park Stops/Bollards	<input type="checkbox"/>
Inadequate Lighting	<input type="checkbox"/>	Other Food	<input type="checkbox"/>	No apparent Reason	<input type="checkbox"/>
Person running	<input type="checkbox"/>	Vomit	<input type="checkbox"/>		

If Other, describe:

OR Caught in:

Door	<input type="checkbox"/>	Escalator/Elevator	<input type="checkbox"/>
Machinery	<input type="checkbox"/>	Other	<input type="checkbox"/>

If Other, describe:

Stepping on or Striking Against:

Display Stands	<input type="checkbox"/>	Escalator/Elevator	<input type="checkbox"/>	Other	<input type="checkbox"/>
Sharp Edges/Protruding Objects	<input type="checkbox"/>	Doors	<input type="checkbox"/>		

If Other, describe:

Other

Falling Objects ☐ If Falling objects, please describe:

Water Damage ☐

Type of surface

Marble	<input type="checkbox"/>	Tile	<input type="checkbox"/>	Carpet	<input type="checkbox"/>	Speed hump	<input type="checkbox"/>
Terrazzo	<input type="checkbox"/>	Timber	<input type="checkbox"/>	Bitumen	<input type="checkbox"/>	Dirt/grass/garden	<input type="checkbox"/>
Slate	<input type="checkbox"/>	Vinyl	<input type="checkbox"/>	Concrete	<input type="checkbox"/>	Other	<input type="checkbox"/>

If Other, describe: _____

WAS INJURED PERSON Reasonable ☐ Upset ☐ Aggressive ☐ Add relevant comments _____

CLEANER ON DUTY: _____ **CLEANING SUPERVISOR:** _____**TIME LOCATION LAST INSPECTED:** _____ **TIME LAST CLEANED:** _____

PLEASE ATTACH WRITTEN STATEMENT FROM CLEANER (If appropriate) _____

RECORD OF INCIDENT Video/closed circuit ☐ Photo ☐ None ☐ _____**INSURANCE HOUSE PRIVACY STATEMENT**

IHGroup is bound by the obligations of the *Privacy Act 1988* (as amended) regarding the collection, use, disclosure and handling of personal information. We will protect the privacy of your personal information.

We collect personal information about you to enable us to provide you with relevant products and services, to assess your application for insurance and, if a contract is entered, to enable us to provide, administer, and manage your policy, and to investigate and handle any claims under your policy. We may disclose your information to third parties (who may be located overseas), such as the insurer, lawyers, claims adjusters, and others appointed by IHGroup or by the insurer to assist us and them in providing relevant products and services. We may also disclose your information to people listed as co-insured on your policy and to your agents. By providing your personal information to us, you consent to us making these disclosures.

If you do not provide all or part of the information required, we may not be able to provide you with our products and services, consider your application for insurance, administer your policy, assess or handle claims under your policy, or you may breach your Duty of Disclosure.

When you provide us with personal information about other individuals, we rely upon you to have made them aware of that disclosure, and of the terms of the IHGroup Privacy Statement, and to obtain their consent.

For a copy of the IHGroup Privacy Statement or to request access to or update the personal information, contact the Privacy Officer at IHGroup by email: ih@ihgroup.com.au or by mail at the address shown on this Proposal.

DECLARATION:

I declare that:

- I am authorised on behalf of the Insured(s) to make this Declaration.
- The information in this Form is true and correct.
- I have read and understood the IHGroup Privacy Statement.

Signature: _____

Name: _____

Title: _____

Date: _____