



DOGS NSW – INCIDENT REPORT FORM

This form must be completed by a representative of DOGS NSW as soon as they become aware an incident has occurred.

All incidents must be reported to DOGS NSW within 48 hours. Please email to info@dogsnsw.org.au

INCIDENT DETAILS	
Date Reported:	Time Reported:
Date Of Incident:	Time Of Incident:
Name of Affiliate / Club Name:	
Location Of Incident:	
Incident Report Completed By:	
Incident Reported To:	
Time Incident Reported To:	Inspected By:

PART 1: INJURED PERSON DETAILS		
<input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Mrs <input type="checkbox"/> Mr <input type="checkbox"/> Other (please specify):	Last Name:	
First Name (in full):	Date of Birth:	
Email:		
Address:		
Phone (H):	(B):	(M):
Other Details:	<input type="checkbox"/> Walking Stick <input type="checkbox"/> Glasses <input type="checkbox"/> Carrying Goods <input type="checkbox"/> Other Impairments:	

PART 2: WITNESS DETAILS		
<input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Mrs <input type="checkbox"/> Mr <input type="checkbox"/> Other (please specify):	Last Name:	
First Name (in full):	Date of Birth:	
Email:		
Address:		
Phone (H):	(B):	(M):
Witness Type:	<input type="checkbox"/> Eye Witness <input type="checkbox"/> Circumstantial Witness	
Relationship:	<input type="checkbox"/> Stranger <input type="checkbox"/> Friend <input type="checkbox"/> Relative <input type="checkbox"/> Colleague	
<i>ATTACH STATEMENTS FOR ADDITIONAL COMMENTS AND/OR ADDITIONAL WITNESS</i>		

If another party responsible, please provide details:

PART 3: PERSONAL INJURY DETAILS

Injury location:			
<input type="checkbox"/> Head & Neck	<input type="checkbox"/> Hip	<input type="checkbox"/> Hands	<input type="checkbox"/> Fingers
<input type="checkbox"/> Eyes or Face	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Knee	<input type="checkbox"/> Back & Trunk
<input type="checkbox"/> Arms & Wrist	<input type="checkbox"/> Feet & Toes		
<input type="checkbox"/> Other (please specify):			

Nature of Injury:		
<input type="checkbox"/> Multiple	<input type="checkbox"/> Minor Bruise – Not Disabling	<input type="checkbox"/> Concussion/Unconscious (Serious)
<input type="checkbox"/> Fracture	<input type="checkbox"/> Major Bruise – Disabling	<input type="checkbox"/> Burns/Scalds – 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"/> Other (please specify):		

Was Injured Person taken to:
<input type="checkbox"/> Treatment by First Aider <input type="checkbox"/> Doctor/Hospital <input type="checkbox"/> Ambulance
Name of First Aider/Person Attending:



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Contact Number:

Other (please specify):

Was a Third Party/Contractor at Fault: Yes No

Third Party/Contractor Name:

Contact Number:

Insurance Details: Insurance Details:

Policy Number:

Expiry Date:

PART 4: ASSOCIATED PROPERTY DAMAGE:

Details of Items Damaged:

Viewed/Inspected by Whom:

Photos Taken by Whom:

PLEASE ATTACH PHOTOS

PART 5: LOCATION OF INCIDENT

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> 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"/> Other (please specify): | | | |

PART 6: TYPE OF INCIDENT

Slip, Trip or Fall of Person Caused by:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> No Apparent Reason | <input type="checkbox"/> Tripped Over Object | <input type="checkbox"/> Food on Floor | <input type="checkbox"/> Lack of Barrier |
| <input type="checkbox"/> Uneven Floor/Ground | <input type="checkbox"/> Rainwater on Floor | <input type="checkbox"/> Beverage/Liquid on Floor | <input type="checkbox"/> Barrier/Signs |
| <input type="checkbox"/> Uneven Steps/Stairs | <input type="checkbox"/> Floor Slippery (Surface) | <input type="checkbox"/> Car Park Stops/Bollards | <input type="checkbox"/> Inadequate Lighting |
| <input type="checkbox"/> Person was Running | <input type="checkbox"/> Vomit/Bodily Fluids | | |
| <input type="checkbox"/> Other (please specify): | | | |

OR Caught in:

- | | | | |
|-------------------------------|---|------------------------------------|--|
| <input type="checkbox"/> Door | <input type="checkbox"/> Escalator/Elevator | <input type="checkbox"/> Machinery | <input type="checkbox"/> Other (please specify): |
|-------------------------------|---|------------------------------------|--|

Stepping on or Striking Against:

- | | | |
|--|--|---|
| <input type="checkbox"/> Display Stands | <input type="checkbox"/> Escalator/Elevator | <input type="checkbox"/> Sharp Edges/Protruding Objects |
| <input type="checkbox"/> Doors | <input type="checkbox"/> Uneven Floor/Ground | |
| <input type="checkbox"/> Other (please specify): | | |

Other:

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Falling Objects | <input type="checkbox"/> Water Damage |
|--|---------------------------------------|

Please Describe:

Type of Surface:

- | | | | | |
|--|----------------------------------|--|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> 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 (please specify): | | | | |

Was Injured Person:

- | | | | |
|-------------------------------------|--------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Reasonable | <input type="checkbox"/> Upset | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Other (please specify): |
|-------------------------------------|--------------------------------|-------------------------------------|--|

