# Employee/Sub Contractor Statement

What are you reporting? (tick which box applies)

**You are injured** □ **Witness to injury** □ **An Incident (near miss)** □

**A Hazard (something that could cause an injury)** □

**Name:** _____ **DOB:** _____ **Length of time with BGC:** _____

**Occupation:** _____ **Occurrence Date:** _____

**Site/Location:** _____ **Occurrence Time:** _____

In detail describe the occurrence including specific location, tools equipment or materials in use and body part affected/applicable)

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|---|
| 1. Describe what actually happened or what you saw: |
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| 2. Where were you at the time? (give specific location eg. Store room) |
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| |
| 3. List what tools/equipment or materials were involved: |
| |
| |
| 4. If applicable, describe what body part has been injured? (eg. Left thumb) |
| |
| |
| 5. In your opinion, what caused the injury/incident or unsafe situation? (eg. Poor lighting, broken trolley wheel) |
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| |
| 6. In your opinion, what could be done to prevent it from happening again? |
| |
| |
| I have given this form to _____ Date: _____ |
| SIGNED: _____ Date: _____ |

| | |
|---|---|
| Managers Signature: | |
| Was medical treatment required? (if yes provide details) | |

*This report is to accompany the Supervisor's Occurrence Investigation form and is to be forwarded to the Group Injury Manager within 24 hours. The occurrence should be discussed at the next Safety/Tool box meeting.

# FIRST NOTIFICATION OF INJURY/ INCIDENT

**THIS FORM MUST BE COMPLETED AND FAXED WITHIN 24 HOURS OF ANY INJURY OCCURING**
**SEND/ EMAIL TO : _____**

| | |
|---|---|
| **DIVISION:** | **ATTN:** Health & Safety Manager<br>**Cc:** Site Manager & Supervisor |

| **INCIDENT DETAILS :** | |
|---|---|
| **INCIDENT DATE:** | **INCIDENT TIME:** |
| **REPORTED DATE:** | **REPORTED TIME:** |
| **REPORTED BY:** | **REPORTED TO:** |
| **RESPONSIBLE SUPERVISOR:** | **RESPONSIBLE MANAGER:** |
| **SITE:** | **LOCATION ON SITE:** |

| **THE INCIDENT/ INJURY/ PROPERTY DAMAGE :** |
|---|
| In sequence, outline the facts of what occurred before and immediately following the incident: |
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| If applicable, list what tools, equipment or materials were involved: |
| List the Personal Protective Equipment (PPE), if any, being worn at the time of the incident/ injury: |

**INJURY/ ILLNESS DETAILS :**

Name:

Injury to BGC Employee? ☐

Injury to Subcontractor? ☐

Injury to Third Party? ☐

Was there a BGC Supervisor on site? ☐ Yes ☐ No

Employment Status: ☐ F/T ☐ P/T ☐ Casual

Was the incident work related? ☐ Yes ☐ No

**Witness To incident/ Injury** (Witness must complete witness statement form)

Name: _____

Occupation: _____

Employer: _____

Home Phone: _____

Mobile: _____

Home Address: _____

| Details Of Injured Person | Injured Persons Employer Details (If not BGC) |
|---|---|
| Full Name: _____ | Employed By : _____ |
| Gender: _____ Age:_____ | Business Phone : _____ |
| Date Of Birth: _____ | Address: _____ |
| Occupation: _____ | Supervisor: _____ |
| Home Phone: _____ | Supervisors Phone: _____ |
| Mobile: _____ | |
| Home Address: _____ | |

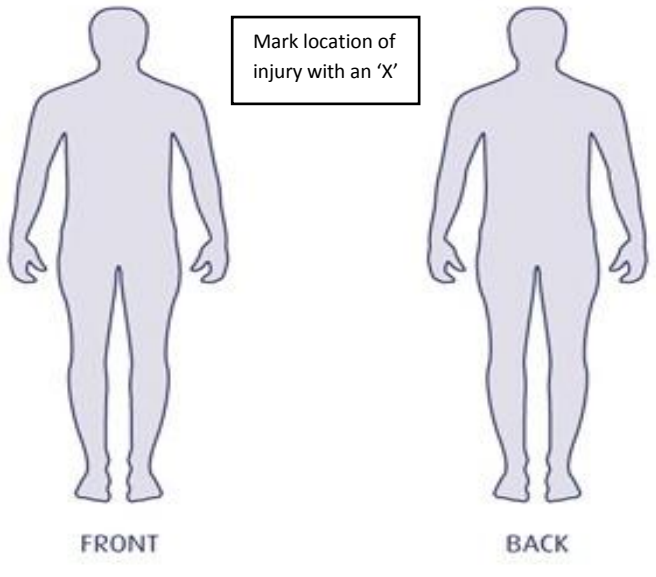
| RETURNED TO WORK? | | | MEDICAL ATTENTION | | | |
|---|---|---|---|---|---|---|
| Same Day: | ☐ | Next Working Day: ☐ | First Aid On Site: | ☐ | Doctor : | ☐ |
| Return to Work Date:_____ | | Has Not Returned Yet: ☐ | Hospital : | ☐ | Other: | ☐ |

## NATURE OF INJURY

| | |
|---|---|
| ☐ Burns & Scalds | ☐ Effects Of Radiation |
| ☐ Concussion | ☐ Effects of Substances |
| ☐ Dermatitis | ☐ Electric Shock |
| ☐ Dislocation | ☐ Fracture |
| ☐ Heart & Vascular Disease | ☐ Thermal Stress |
| ☐ Internal Injuries | ☐ Superficial Injuries |
| ☐ Open Wound | ☐ Inflammation |
| ☐ Sprains & Strains | ☐ Infection & Parasitic Disease |

## SOURCE OF ENERGY

| | |
|---|---|
| ☐ Fall Of Person | ☐ Striking Against/ Struck By Self |
| ☐ Stepping/ Standing/ Sitting | ☐ Muscle Effect |
| ☐ Rubbing Or Abrading | ☐ Sound & Vibration Exposure |
| ☐ Thermal Energy Contact | ☐ Psycho-Social Stressor Exposure |
| ☐ Fluid Pressure Exposure | ☐ Falling Swinging/ Descending Objects |
| ☐ Attacks | ☐ Corrosive Substance Exposure |
| ☐ Flying/ Moving Object Impacts | ☐ Other |
| ☐ Grasping Or Touching | |




## RISK ASSESSMENT:

| | | | |
|---|---|---|---|
| Copy Of SAT (white card attached) | ☐ | Copy of Site Induction attached | ☐ |
| Copy Of High Risk License attached | ☐ | Copy Of JSA attached | ☐ |

## PROPERTY LOSS OR DAMAGE:

| | |
|---|---|
| **BGC Vehicle Loss Or Damage: Yes ☐ No ☐** | **Loss Or Damage To Third Party: Yes ☐ No ☐** |
| BGC Driver Name : _____ | Name: _____ |
| BGC Vehicle Registration Number : _____ | Address: _____ |
| Is the BGC Vehicle Serviceable? Yes ☐ No ☐ | Phone: _____ Registration No: _____ |
| Estimated Cost : $_____ | Estimated Cost of loss/ damaged to Third Party $ _____ |
| Have Police been informed? Yes ☐ No ☐ | Have Police been informed? Yes ☐ No ☐ |

| | | |
|---|---|---|
| **BGC Equipment/ Property Loss Or Damage: Yes ☐ No ☐**<br>Type Of Property/ Equipment Involved: _____<br>_____<br>Estimated Cost of loss/ damage to BGC property: $_____<br>Have Police been informed? Yes ☐ No ☐<br>If yes, Police Report Number: _____ | ☐ Mobile Plant<br>☐ Furniture<br>☐ Fixed Plant<br>☐ Tools<br>☐ Auxiliary Plant<br>☐ Building<br>☐ Light Vehicle<br>☐ Sundry Equipment<br>☐ IT/ Electronic | ☐ Other<br>Please Specify:<br>_____ |

## ANY ADDITIONAL COMMENTS?

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|---|---|
| Full Name : | Signature : |
| Telephone : | Date : |