

Airside Operators INCIDENT NOTIFICATION

Supervisor to ensure this form is completed immediately after an incident has occurred and forwarded to Cairns Airport Pty Ltd for signoff within 24 hours of the incident. Incidents include near misses.

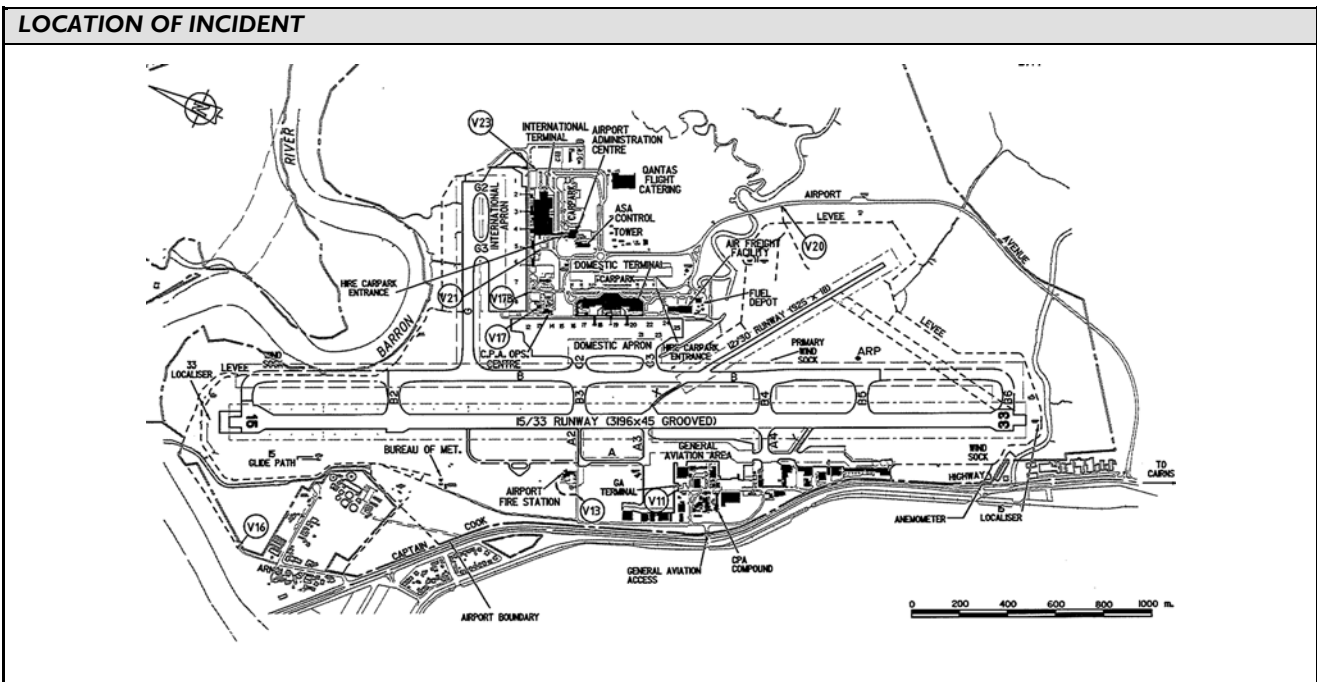
INCIDENT DETAILS			
Date of Incident	Time	Aircraft details (If applicable)	
Nature of Incident		Aircraft Type	
Location of Incident		Registration	
Date Reported	Time	Flight No.	
Reported by			
Organisation			
PERSON INVOLVED or INJURED			
Given Names		Lost Time Injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> TBA
Surname		Occupation	
Phone		Employer	
Email			
WITNESS DETAILS			
Witness Name:			
Contact Details			
D.A.M.P. TEST			
	Completed ? <input type="checkbox"/> Yes <input type="checkbox"/> No		

BRIEF DESCRIPTION OF INCIDENT / SEQUENCE OF EVENTS	
Initial Contributing Factors	
INCIDENT DATA	
Type of Injury:	<input type="checkbox"/> NEAR MISS <input type="checkbox"/> MINOR <input type="checkbox"/> SERIOUS BODILY INJURY <input type="checkbox"/> DANGEROUS EVENT <input type="checkbox"/> DANGEROUS ELECTRICAL EVENT <input type="checkbox"/> FATALITY <input type="checkbox"/> WORK CAUSED ILLNESS
	Damage to CAPL Equipment? _____ Damage to Non-CAPL Equipment? _____ Damage to Environment? <input type="checkbox"/> Yes → Environmental Report must be completed <input type="checkbox"/> No

TYPE OF INCIDENT			
<input type="checkbox"/> LIFTING	<input type="checkbox"/> SLIP / TRIP / FALL	<input type="checkbox"/> STRIKING	<input type="checkbox"/> POISONING
<input type="checkbox"/> INHALATION	<input type="checkbox"/> BURNING	<input type="checkbox"/> TEMPERATURE	<input type="checkbox"/> DISEASE
<input type="checkbox"/> ELECTRIC SHOCK	<input type="checkbox"/> EXPLOSION / COLLAPSE	<input type="checkbox"/> OTHER (Please specify) _____	
AGENCY OF INJURY			
<input type="checkbox"/> MANUAL HANDLING	<input type="checkbox"/> ELECTRICITY	<input type="checkbox"/> WORKING ENVIRON	
<input type="checkbox"/> OTHER EQUIPMENT	<input type="checkbox"/> TRANSPORT	<input type="checkbox"/> STEAM	
<input type="checkbox"/> HAND TOOLS	<input type="checkbox"/> PLANT	<input type="checkbox"/> BLDG / STRUCTURE	
<input type="checkbox"/> GAS	<input type="checkbox"/> POWER HAND TOOLS	<input type="checkbox"/> SPEC PLANT	
<input type="checkbox"/> TRENCH / EXCAVATION	<input type="checkbox"/> OTHER (Please specify)		

please continue over page

THIS INVESTIGATION IS AIMED AT IDENTIFYING CAUSES NOT ATTRIBUTING BLAME



CORRECTIVE / PREVENTATIVE ACTION TO BE TAKEN:							
RESPONSIBILITY:	PROPOSED COMPLETION DATE:						
SUPERVISOR'S COMMENTS (consider if AOD testing is required)							
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">Name:</td> <td style="width: 50px;"></td> </tr> <tr> <td style="padding: 2px;">Signature:</td> <td></td> </tr> <tr> <td style="padding: 2px;">Date:</td> <td></td> </tr> </table>	Name:		Signature:		Date:	
Name:							
Signature:							
Date:							

WHSQ notified ?	<input type="checkbox"/> YES <input type="checkbox"/> NO
POLICE notified ?	<input type="checkbox"/> YES <input type="checkbox"/> NO
CASA notified ?	<input type="checkbox"/> YES <input type="checkbox"/> NO
ATSB notified ?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Airport Environmt Officer notified?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Request for access to CCTV Footage ?	<input type="checkbox"/> YES <input type="checkbox"/> NO

When completed, email form to the following CAPL personnel:

barbara.cole@ Cairnsairport.com.au and
paul.lamont@ Cairnsairport.com.au