

Insert Business name where any line _____ indicates

<p>Your Business Logo is inserted here</p> <p>Business Initial here</p> <p>Policy and Procedure number here</p> <p>"PP" here</p>	<p>Document Title INCIDENCE REPORTING Policy and Procedure</p> <p>CE-PP-01</p> <p>DATE COMPLIED: 26/11/2004 REVIEW DATE: 26/11/2005 Authorised By: Compiled By: B&L Safety Solutions</p>	<p>Policy & Procedure name here</p> <p>Date Document Drawn up</p> <p>Review Date Authorised By</p>
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Business name inserted here

POLICY
In keeping with _____ commitment to safety for all our employees and visitors, and our continuous safety program. This Policy and Procedure shall be adhered to by all employees and visitors. This Policy and Procedure is to be observed and signed by all employees in keeping with our consultation arrangement/agreement for reporting of all incidence's and accidents.

PROCEDURE

1. Under Section 341 of the Occupational and Safety Regulations *Notification of incidents—additional incidents to be notified:*
 - a) Injury to a person regardless of how minor, shall be registered in the Workplace Injury and Disease Register.
 - b) That all injuries shall be reported to the manager/supervisor who will organise for the injured person to be treated for first aid or to see the Doctor.
 - c) The manager shall then assist the injured person to fill in the incident report log with a full description of how the incidence occurred.
 - d) That employees are aware of the regulation that Insurers MUST be notified of a significant injury within 48 hours of the injury occurring
2. In the event of a series injury (amputation, crush, death, extreme damage to machinery). The manager shall: under sections 86 (1) and 87 (4) *Non Disturbance of place and plant involved in serious incidents—additional serious incidents .*
 - a) Immediately after ensuring that the injured person has medical attention, or (machinery has been isolated) shall notify Workcover of the incidence.
 - b) Ensure that the scene of the incidence shall not be disturbed for a minimum of 36 hours, or unless Workcover representatives inform him otherwise.
3. That records of all incidences shall be kept on file for a minimum of five (5) years,

In addition to the above _____ shall:

1. Keep all records in a completed and tidy manner in accordance with our procedures.
2. That our incidence records are accessible at any time.
3. We shall maintain our records as to the regulations required by Workcover and the NOHSC.
4. That all incidences recorded are investigated thoroughly.
5. We shall review our policy on incidents and accidents each year in accordance with our procedure.
6. Maintain a First Aid Register for minor incidents (cuts and abrasions)
7. Ensure all employees are aware of all record keeping procedures, and review this each year.
8. Ensure that an investigation of all incidence's will be carried out and an evaluation of the incidence's shall be performed.

This policy and Procedure is to be reviewed every 12 calendar months

Business Name Here

Procedures

Policy

Signatures and dates here

Managers Signature

Employees Name

Date Implemented / /

Employees Signature



	<u>DOCUMENT TITLE</u> Employment/Application Policy Policy and Procedure	
	OH&S <u>Document Number</u> <u>-PP-</u>	DATE COMPLIED: / / REVIEW DATE: / / Authorised By: Compiled By: <i>B&L Safety Solutions</i>

Thank you for your interest in applying for a position with our organisation.
To assist with our decision, could you please provide the following confidential information
While it is not mandatory for you to provide this information, you should be advised that if we are unable to form a clear picture of your pre-employment history, this may have an adverse effect on your proposed employment with our organisation. Note that any information collected about unsuccessful candidates will not be retained unless your express permission is provided to this organisation to do so.

Position Applying For _____

Date of Application / /20.

Surname _____

Given Names _____

First Name Middle Name(s) _____

Home Address _____ P/C _____

(optional) Date of Birth / /

(optional) Marital Status- currently married? Yes No

Telephone No. Private () _____ Nearest () _____

Driver's Licence No. _____ Expiry Date//

Driver's Licence Endorsement Details _____

NOTE: Information disclosed herein in relation to **motor vehicle accidents** or any driving offences will not preclude any applicant from equal consideration.

Have you ever been involved in any motor vehicle accident, as a driver?

No Yes If yes, give details: _____

Have you ever been convicted of driving a vehicle under the influence of alcohol or drugs?

No Yes If yes, give details: _____

2. _____ () _____ () _____

Name of Contact

STD Ph. No. (B.H.)

STD Ph. No. (A.H.)

Address of Contact

Relationship

NOTE: Information disclosed herein in relation to any illness, disease or workers compensation will not preclude any applicant from equal consideration.

Do you suffer or have you ever suffered any of the following?

Heart disease Yes No

Strains/sprains Yes No

Diabetes Yes No

Back/neck pain Yes No

Epilepsy Yes No

Shoulder/arm pain Yes No

Pain in Joints Yes No

Hearing Impairment Yes No

Problem Vision Yes No

Asthma Yes No

If yes to any of the above, give details:

Have you had any other serious illness/disease in the past five (5) years?

No Yes If yes, give details _____

Have you ever received or are you currently receiving workers' compensation or made a claim for a work related injury?

No Yes If yes, give the following details _____

Date of Injury/Claim	Nature of Injury/Claim	Name of Employer
/ /	_____	_____
/ /	_____	_____

Are you aware of any physical handicaps or disabilities which would prevent you from performing specific kinds of work for the function you are applying for, or for any other functions?

No Yes

If yes, describe the handicap or disability and the resultant work limitations.

... [form could then continue to request other relevant information about candidate...]

Are you prepared to undergo a paid medical examination prior to being offered employment?

Yes No

I hereby declare that my answers supplied to the questions on this application are, to the best of my knowledge and belief, true and correct.

I understand and agree that the employment offered is based upon the accuracy of information contained herein and any misrepresentation of facts or material omission could be cause for dismissal.

I hereby agree that the company may approach/contact any previous employer and/or any referee shown on this application.

Signature of Applicant _____ Date / /

Signature of Interviewer _____

COMMENTS

Have you ever

- 12. Injured/strained your back Yes No
- 13. Had fits or convulsions Yes No
- 14. Had a head injury Yes No
- 15. Had a hernia or rupture Yes No
- 16. Had nerve trouble - ie been treated for stress or similar symptoms
Yes No
- 17. Taken medicine regularly Yes No
- 18. Had diabetes Yes No
- 19. Had high blood pressure Yes No
- 20. Had allergies or reactions to drugs Yes No
- 21. Had asthma or bronchitis Yes No
- 22. Had fainting spells or dizziness Yes No
- 23. Had shortness of breath Yes No
- 24. Had heart trouble Yes No
- 25. Had joint pain or stiffness Yes No

Have you been immunised against tetanus? If yes, when
.....

If "yes" to any of the above, please
detail: _____

I hereby certify that the information given by me in the pre-employment medical report is true and complete in every respect and fully discloses any existing or previously experienced medical condition, to the best of my knowledge.

I agree that the Company shall not be liable in any respect if my employment is terminated because of falsity of statements, answers or omissions wilfully made by me in the questionnaire.

I hereby authorise Dr _____ (company doctor) to provide the Company with a copy of the medical examination to be given to me on ___/___/___ and to release such information relative to this examination as is necessary to ensure my own health and the health and safety of others with whom I might work.

Signed _____ (Applicant)

Witnessed _____ (Physician)

Date _____

Name _____ Age _____

Sex _____

Address _____

Job Offered:

Mechanic/Labourer/Clerk/Operator/(specify)/ _____

The statements made in this questionnaire are true and to the best of my knowledge correct. I understand that any mis-statement of facts is grounds for release.

Signed: _____ (Applicant)

Place of Examination _____

Witnessed: _____

(Examining Physician) _____

Date _____

Place of Examination _____

Medical Examination Report

CONFIDENTIAL

TO: The Administration Superintendent (address of company)

(Applicant's Name)

Position Applied For: _____ (please print)

I have on ____/____/____ examined the above-named person and consider him/her to be:

Acceptable

Not Acceptable

for employment with your company engaged in:

- 1. Strenuous Work (driver - operator, etc.)
- 2. Moderately Strenuous Work (mechanic)
- 3. Clerical Work

The candidate's Medical History Form has been completed, and a copy placed in my files.

Yours sincerely,

MBBS (Examining Physician)

Physician's Name & Address (Please Print or Stamp)

