

# Incident Report – Manual Handling

## Muscular/Skeletal Injury

Reported by:		Date:	
Name of injured person:		Date of injury:	
Division/Location:		Age:	
Particulars of incident:			
Associated property damage:			
Nature of the injury:			
Cause of the injury:			

## Did any of the following manual activities contribute to the injury?

Activity	Yes	No	Comment
Repetitive or sustained application of force	<input type="checkbox"/>	<input type="checkbox"/>	
Repetitive or sustained awkward posture	<input type="checkbox"/>	<input type="checkbox"/>	
Repetitive or sustained posture	<input type="checkbox"/>	<input type="checkbox"/>	
Application of high forces	<input type="checkbox"/>	<input type="checkbox"/>	
Exposure to sustained vibration	<input type="checkbox"/>	<input type="checkbox"/>	
Handling people or live animals	<input type="checkbox"/>	<input type="checkbox"/>	



Handling loads that are unstable, unbalanced or difficult to move	<input type="checkbox"/>	<input type="checkbox"/>	
Twisting	<input type="checkbox"/>	<input type="checkbox"/>	
Reaching high or low	<input type="checkbox"/>	<input type="checkbox"/>	
Comments:			