University of Queensland Union

Volunteer Grievance Form

Volunteers have the right to express grievances, concerns or dissatisfaction with the Volunteer Programme or operations and to have grievances dealt with in an efficient, equitable and fair manner. Refer to the Grievance Policy for details of the procedure by which grievances are reported and managed.

Date: ____ / ____ / ____ Person/s making report: _____

Person/s Involved: _____

_____

_____

Date of Incident: ____ / ____ / ____ Time of Incident: _____

Location of Incident: _____

Description of Incident: _____

_____

_____

_____

Please attach extra pages if necessary

_____ _____ _____

Name (please print) Signature Date

Volunteer Coordinator Use (Tick ✓, Initial and Date)

☐ Grievance Recorded	☐ Action	☐ Notification
☐ Follow-up	Comments:	

Name:	Position:
Contact Phone Number:	Date of birth:
Area/Department:	Supervisor/Manager:
Employed in this position ☐ years ☐ months	Full-time ☐ Part-time ☐ Casual ☐ Visitor ☐ Student ☐ Other ☐

Event Details

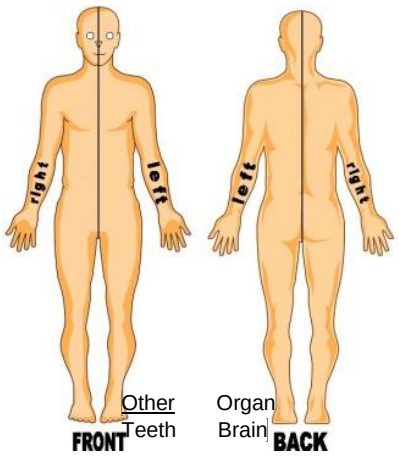
Date of event / /	*Time of event* : am/pm	*Activity at time of event* On duty ☐ Travel to/from work ☐ Meal/Break ☐ Other ☐
Place of event Room Building Campus		
Description of events (Describe tasks being performed and list sequence of events). Attach further information overleaf if space is insufficient and add sketches and photographs, plus information from witnesses if applicable.		

Injury details

Nature or type (please circle)

Amputation
Asphyxiation
Bruise or crushing
Burn or scald
Concussion
Cut or open wound
Dislocation
Exposure
Foreign body
Fracture
Heart or circulatory condition
Infectious disease
Inhalation
Internal injury
Nervous system injury or disorder
Poisoning
Puncture
Respiratory (inhalation)
Skin disorder
Sprain or strain
Other (specify)

Body Part (mark the injured part/s)



Agent of damage (please circle)

Animal or insect
Biological
Chemical
Electricity
Equipment or tool:
- powered
- not powered
Explosion or implosion (pressure)
Muscular effort:
- singular event
- repetitive or postural
Needle or sharp *(refer page 2 of document)*
Noise
Psychological
Radiation
Slip, trip or fall *(refer page 2 of document)*
Stepping on or striking against object
Struck by falling or moving object
Thermal (heat or cold)
Vehicle
Vibration
Other (specify)

Medical treatment obtained

Nil ☐ First Aid ☐ University Health Service ☐ Hospital casualty ☐
Hospital admitted ☐ Other Doctor ☐ Other ☐

Outcome for injured person

Time lost from work .....days .....hours Not yet returned to work ☐

Signature of person injured or involved: ..... date: ..../..../....

Submit to HR Department

Received by WHSO date:	Name:	Signature:
Action: See investigation report form		

Section to be filled out by the person injured or involved

If slip, trip or fall involved, provide additional information

Slip/fall along the ground ☐ Condition of walking surface ……

Slip/fall on stairs or sloping surface ☐ Type & condition of footwear ……

Falls from height ☐ What was being done at time of incident ……

If needle or sharps injury/incident:

Was the needle or sharp sterile? Yes No

Has the person been subsequently tested for HIV, Hepatitis B & Hepatitis C? Yes No

Section to be filled out by the supervisor

Information about personal protective equipment (PPE)

Should PPE have been worn during the task being undertaken at the time of the incident? Yes No

Was it available? Yes No

Was it being worn/used? Yes No

Type of PPE required: .....

Corrective action	**Action Taken**	**Date**
Changes to work environment:		
Modifications or repairs to machinery, equipment or tools		
Changes to work practices/job design		
Personal protective equipment (additional or changes)		
Additional Training		

Signature of supervisor ..... Please print name: .....

List any difficulties in implementing the corrective action recommended above: .....

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Additional information *(if required)*: .....

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