

INJURY / INCIDENT FORM



Event Number: _____ (Coverstaff to fill in)

THE INJURED PERSON		
Name:		Address:
Phone:	DOB:	

EVENT DETAILS			
Date:	M T W T F S S	Time:	Date Reported:
Date of Accident:	Time on assignment:		
Company working for:		Location:	

EVENT TYPE	SEVERITY OF EVENT	TREATMENT DETAILS
<input type="checkbox"/> Near Miss	<input type="checkbox"/> Minor: First Aid less than one day of work	<input type="checkbox"/> None <input type="checkbox"/> Doctor
<input type="checkbox"/> Injury	<input type="checkbox"/> Moderate: Doctor and/or 1-5 days off work	<input type="checkbox"/> First Aid <input type="checkbox"/> Hospital
<input type="checkbox"/> Property Damaged	<input type="checkbox"/> Serious: See 'Serious Harm' definition	<input type="checkbox"/> Nurse <input type="checkbox"/> Physio
<input type="checkbox"/> At Risk Behaviour	<input type="checkbox"/> Potentially Serious	<input type="checkbox"/> Other provider:
<input type="checkbox"/> Illness	<input type="checkbox"/> Unknown at this stage	

INJURY DETAILS – BODY PART	INJURY TYPE (please tick)	
Shade the part of the body that is injured 	<input type="checkbox"/> Aches / Pain (gradual)	<input type="checkbox"/> Dental Injury
	<input type="checkbox"/> Aches / Pain (sudden)	<input type="checkbox"/> Dermatitis
	<input type="checkbox"/> Amputation	<input type="checkbox"/> Dislocation
	<input type="checkbox"/> Broken Bone	<input type="checkbox"/> Fatal
	<input type="checkbox"/> Bruising (including Crushing)	<input type="checkbox"/> Foreign Body <input type="checkbox"/> Eye <input type="checkbox"/> Nose <input type="checkbox"/> Ear
	<input type="checkbox"/> Burn / Scald	<input type="checkbox"/> Fracture
	<input type="checkbox"/> Chemical Reaction	<input type="checkbox"/> Inhalation Disease (asbestos/lead)
	<input type="checkbox"/> Choking / Suffocation	<input type="checkbox"/> Hearing Loss (noise incl)
	<input type="checkbox"/> Concussion / Brain Injury	<input type="checkbox"/> Multiple Injuries
	<input type="checkbox"/> Cut (infected)	<input type="checkbox"/> Poisoning
<input type="checkbox"/> Cut (not infected)	<input type="checkbox"/> Strain / Sprain	
<input type="checkbox"/> Other:		

PLEASE TURN OVER



What happened? (use extra paper if necessary – draw diagram below if required)

--

What do you think caused or contributed to the incident?

--

Space for Diagram or further notes

--

DAMAGED PROPERTY

Describe damage:

Nature of damage:

Object / substance inflicting damage:

Employees Signature: _____

Date: _____

Managers Signature: _____

Date: _____

(This confirms it has been recorded)