

INCIDENT/ACCIDENT REPORT

To be completed by the injured person.

Host Company information

Name of Host Company: _____

Host Company address: _____

Host Company telephone number: _____ Host Company fax number: _____

Injured person and nature of injury

Name of the injured person: _____

Nature of the injuries: _____

Sex: M F Date of Birth: _____

Residential address: _____

Occupation or duties: _____

Location of the workplace where the injury occurred:

Date of the injury: _____ Time of the injury: _____

Start time of shift: _____ Finish time of shift: _____

Work being done at the time of the occurrence of injury: _____

Brief description of the circumstances surrounding the occurrence of the injury:

Nature, extent and bodily location of the injury:

Estimated period of incapacity: _____

Has the patient been conveyed to hospital and likely to be admitted? _____

Occupational Physician

Name of Occupational Physician: _____

Physician's telephone number: _____ Physician's fax number: _____

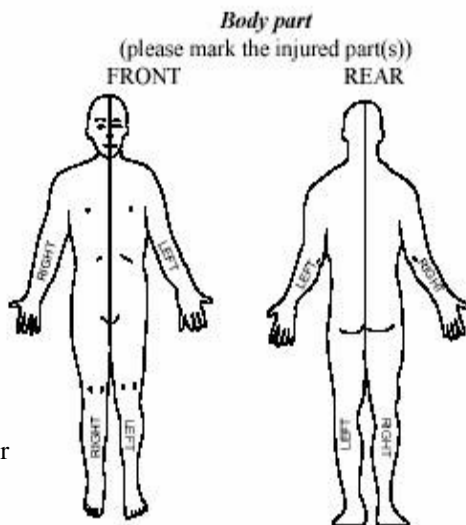
If death has occurred, the cause, date, time and place of death:

Names and addresses of any eyewitnesses to the injury:

Name of witness A: _____ Name of witness B: _____

Address of witness A: _____ Address of witness B: _____

- 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) _____



- Animal or insect
- Biological
- Chemical
- Electricity
- Equipment or tool-powered – not powered
- Explosion/implosion (pressure)
- Muscular effort-single repetitive or postural
- Needle or sharp
- Noise
- Psychological
- Radiation
- Slip, trip or fall
- Stepping on or striking against an object
- Struck by falling or moving object
- Thermal (heat cold)
- Vehicle
- Vibration
- Other (specify) _____

Teeth _____
Brain _____
Organ (specify) _____

Description of first aid administered (ie. Band-aid, irrigation etc.)

Name of the person administering first aid:

_____ Signature: _____

Name and address of the injured person:

_____ Signature: _____

Street Address _____ Suburb _____

State _____ Postcode _____

Accident investigation completed Yes / No

Signature: _____ Date: _____

Has the accident been reported to Workplace Standards Yes / No

Signature: _____ Date: _____