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Transforming Aspirations into Australian Health Careers

Incident and Injury Report Form

Information regarding the injury (e.g., to an employee or guest) and the medical care provided	
Date and Time of Incident:	Date: / / Time: am / pm
Nature of Incident:	☐ Near miss ☐ First aid ☐ Medical treatment/Doctor
Injured Individual's Name:	
Address:	
Occupation:	
Date of Birth:	
Telephone:	
Employer:	
The activity the individual was involved in when the injury occurred:	
The precise location where the injury took place:	
Type of injury (e.g. fracture, burn, sprain, or foreign object in the eye):	

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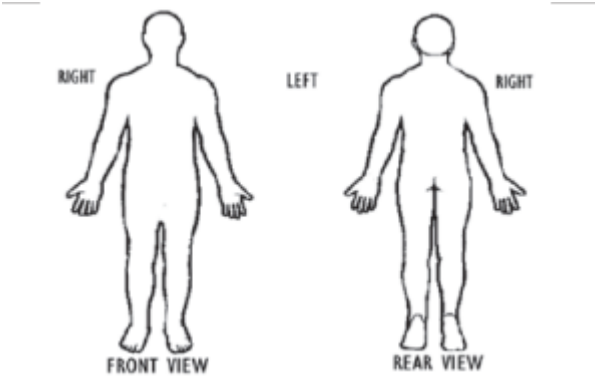
Injury location on the body (mark the injury's position on the diagram):	

Medical care given at the site:		**Name of Treating Person:**	
Recommendation for additional medical attention? ☐ Yes ☐ No	**Name of Doctor or Hospital:**	**SafeWork NSW medical certificate received and attached to this form?** ☐ Yes ☐ No	**Copy attached?** ☐ Yes ☐ No
Injury management required? ☐ Yes ☐ No	**Return to Work Coordinator notified?** ☐ Yes ☐ No	**Name of Return to Work Coordinator:**	

Witness who observed the incident (each witness may be required to provide a description of the events).			
Witness Name:		**Contact Information:**	
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Specifics of the Incident (e.g., damage to property, equipment, or the environment).			
Date of Incident:		**Time of Incident:**	am / pm
Location of Incident:			
Description of the damage to equipment or property:			
Name of the individual who received the report:		**Contact Information:**	

Incident Details - Describe the Incident

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Prompt actions taken in response (e.g., setting up barriers, isolating power) to stabilise the situation.

Report Details	
Reported to Principal Contractor? ☐ Yes ☐ No	Provide specific details (date, reported to, and reported by).
Reported to authorities (SafeWork NSW phone: 13 10 50)? ☐ Yes ☐ No	Provide specific details (date, reported to, and reported by).
Reported to Principal Contractor? ☐ Yes ☐ No	Provide specific details (date, reported to, and reported by).
Reported to workers' compensation insurer? ☐ Yes ☐ No	Provide specific details (name of insurer and claim number).

Completed by:			
Name:		**Position:**	
Signature:		**Date:**	