

INCIDENT REPORT FORM

Section 1 – Details of Injured Person

Full Name:			
Contact Tel:		Mobile:	
Address:			
Email:			

Section 2 – Details of Incident

Date of Incident:		Time:	____: ____ am/pm
Location of Incident:			
Reported to:		Position Title:	

Description of incident: (What and how the incident occurred)

Section 3 – Details of Injury and Treatment

Description of injury:

Treatment Provided:

Further Treatment Recommended:

- None
 Other (please describe)

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Section 4 – Witnesses to Incident

The following persons witnessed the incident:

Name 1:		Contact:	
Address:			
Signature 1:		Date:	/ /
Name 2:		Contact:	
Address:			
Signature 2:		Date:	/ /

Section 5 – Signatures

Supervisor:

Signed:		Position:	
Print Name:		Date:	

First Aider:

Signed:		Position:	
Print Name:		Date:	

Director:

Signed:		Position:	
Print Name:		Date:	

Admin Use Only

Reported to Insurer:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:	/ /
Reported By:			Signature:	
Reported to Worksafe:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:	/ /
Reported By:			Signature:	