



ACCIDENTS & INJURIES REGISTER

Date: ...../...../.....

**Company Advised on:** ...../...../20.... **Person Advised:** ..... **Signature:** .....

**Employee Name:** ..... **Address:** .....

**Suburb:** ..... **State:** ..... **Post Code:** .....

**Phone:** ..... **Fax:** ..... **E-mail:** .....

Time and Date of the Accident/Injury	Time: .....am/pm Date:...../...../.....
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Work being undertaken at time of the Accident/Injury	..... .....
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Location at the time of the Accident/Injury	..... .....
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Treatment required	<input type="checkbox"/> First Aid <input type="checkbox"/> Clinic <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Hospital Stay
First Aid/Clinic/Hospital Transport to Treatment	Name of First Aid: .....Clinic: ..... Hosp.: ..... <input type="checkbox"/> Drove Self <input type="checkbox"/> Driven by Others <input type="checkbox"/> Ambulance

Witnesses to the Accident/Injury	Name:..... Phone:..... Email: .....
	Name:..... Phone:..... Email: .....

Notification of Persons listed as first contact	Name:..... Time: .....am/pm Date:...../...../.....
	Name:..... Time: .....am/pm Date:...../...../.....
	Notified by:.....

Confirmation to Employee Or Employees representative	Written confirmation of claim made by: .....
	<input type="checkbox"/> Post Mail <input type="checkbox"/> Fax <input type="checkbox"/> Email on Date:...../...../.....

Site Investigator Internal	Name:.....Phone:.....
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Workcover Notification Workcover main contact	Date:...../...../..... Contact:.....Phone:.....
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Insurer Notification Insurers main contact	Date:...../...../..... Contact:.....Phone:.....
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**Details of Accident/Injury:** .....

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**Any Other Comments:** .....

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PLEASE ALSO SEE CORRECTIVE ACTION REPORT



INCIDENT/CORRECTIVE ACTION REPORT

Date of Incident: ...../...../..... Time: ..... Report By:.....

Type of Incident:  1.Accident requiring medical attention  2.Other Accident(non medical)  3.Near Miss

Name of Person in Incident.....

Accident requiring medical attention

Medical Attention: First Aid Medical Centre Doctor Hospital Other: .....

Part of Body: Eye Foot Ear Trunk Head Hand Leg Arm Other: .....

Type of Injury: Cut Burn Foreign Body Bruise Hearing Fracture Strain Other.....

Accident requiring medical attention , Other Accident, Near Miss

Type of Incident: Fall, Trip, Jump Manual Handling Exposure Struck by Caught in/between

Other: .....

Incident Involved: Machinery Equipment Power Tools Hand Tools Chemicals Lifting

Ladders Access Equipment Other: .....

Cause of Incident(description): .....

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Contributing factors: Fatigue Rain Heat Ill Health Cold Wind Alcohol/Drugs

Other Workers(ours) Other Workers(not ours) General Public Lack of PPE

Incorrect or no Warning Equipment(Witches hats, Tape etc) Low Visibility

Any Other Factors: .....

Corrective Action

Unsafe Conditions: Remove Repair Replace Guard Improve Warn of Other: .....

Unsafe Act: Counsel Asses Work Practice Instruct Employee Improve Protect Other: .....

What can we do to prevent similar: .....

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Further Recommendations:.....

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Follow Up:.....

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Signature:..... Date: ...../...../.....