INCIDENT REPORT FORM

PARTICULARS OF PERSON INVOLVED IN INCIDENT		Date injury/illness reported	
Full Name		Date of Birth	
Position		Department	
CONTACT DETAILS IF NON-EMPLOYEE			
Phone No		Mobile No	
Address			
DESCRIPTION OF CIRCUMSTANCES			
Date of injury/illness		Time of injury/illness	❒ AM ❒ PM
Nature of injury/illness			
Bodily location of injury/illness (for illnesses, include symptoms)			
Location at time of injury			
How was the injury/illness sustained (cause of injury/illness)			
Was any plant, equipment, substance, or thing involved in the injury?			❒ YES ❒ NO
If YES, please provide details.			
WITNESSES	Were there any witnesses to the injury?		❒ YES ❒ NO
Name		Contact	
Name		Contact	
Name		Contact	
Name		Contact	

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FOLLOW-UP			
Has the injury/illness been reported to the worker's supervisor?			❒ YES ❒ NO
Was any treatment provided?	❒ YES ❒ NO	If YES, please provide details below.	
Did the injured/ill worker return to work following the injury/illness?			❒ YES ❒ NO
If YES, please provide details.			

PARTICULARS OF PERSON INVOLVED IN INCIDENT			
First Name		Last Name	
Position		Department	
Signature		Date	

Submit form to YOUR:

1. Immediate supervisor
2. Human Resources
3. HSR (Elected Health and Safety Representative)
4. Union Organiser

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TO BE COMPLETED BY MANAGER/SUPERVISOR OF INJURED/ILL WORKER	
Has an investigation been conducted into the incident?	❒ YES ❒ NO
If yes, by whom?	
What controls have been implemented to ensure the incident doesn't happen again?	

EMPLOYER CONFIRMATION

I, _____ (print name), of

_____ (print company name)

Hereby confirm receipt of this notification.

Signature: _____ **Date**: _____