

# active TRAINING

## 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. Include if Emergency Services called)

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### Section 3 – Details of Injury and Treatment

Description of injury:

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Treatment Provided:

<input type="checkbox"/> None Required	<input type="checkbox"/> Taken to Doctors Surgery (provide detail)
<input type="checkbox"/> First Aid (please describe)	.....
.....	.....
.....	<input type="checkbox"/> Taken to Hospital (provide detail)
.....	.....
	.....
	<input type="checkbox"/> Ambulance called and attended

Further Treatment Recommended:

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- ☐ None
- ☐ Other (please describe e.g counselling)

### 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:	

CEO:

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 SA:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:	/ /
Reported By:			Signature:	
Incident Report filed			Signature:	