# FORM-15. Injury Report

Complete this form to record details of injuries that require or have the potential to require (back or joint injury) medical treatment

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| **Name of injured person:** | | | **Employee  Visitor  Contractor** | | | |
| **If Employee –Job Title: DoB:** \_\_/\_\_/\_\_ **Age: Marital Status:** | | | | | | |
| **Contact Details - Address:** | | | | | **Ph:** | |
| **Date and time of injury/illness: Time:** \_\_:\_\_  **Date:** \_\_/\_\_/\_\_ | | | | | | |
| **OR Date person became aware of injury/illness:  Date:** \_\_/\_\_/\_\_ | | | | **Notification of injury/illness:  Date:** \_\_/\_\_/\_\_ | | |
| **Location of the accident or where employee became unwell: At the workplace   Away from the workplace** | | | | | | |
| **Exact Location:** | | | | | | |
| **What part of the body was injured as a result of the accident? (Describe and/or circle on diagrams):** | | | **Front view**  **Rearview** | | | |
| **Describe the nature of the injury/illness. (e.g., cut):** | | |
| **Describe the cause of the injury/illness and the work task being undertaken. (e.g., hit by a box falling from the shelf):** | | | | | | |
| **What treatment was received following the accident? (E.g., bandage put on cut, sent to casualty):** | | | | | | |
| **Witnesses:** Yes  No | | | | | | |
| **Contact details:** | | | | | | |
| **Name** | **Address** | | | | | **Phone** |
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| **Accident Incident Form Completed:**  Yes  No | | **Workers Compensation Claim lodged:**  Yes  No | | | | |
| **Injury Report Completed - Time:** \_\_:\_\_ **Date:** \_\_/\_\_/\_\_ | | | | | | |
| **Completed by: Name:**  **Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | |
| **Management Name: Injured Person Name:**  **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Position: Date: \_\_/\_\_/\_\_**  **Date: \_\_/\_\_/\_\_** | | | | | | |