# 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: \_\_/\_\_/\_\_** |