

Register of Injury

Details of Injured Person

NAME: Surname: _____ Given Name(s): _____ Sex (M/F): _____
Address: _____ Suburb: _____ Post Code: _____
City: _____ State: _____ Contact Phone: _____

EMPLOYER: Business Name: _____
Address: _____ Suburb: _____ Post Code: _____
City: _____ State: _____ Business Phone: _____

Accident/ Incident Details

Description of Events:

Date of Injury: _____ Time of Injury: _____ am/pm

Task/ operation undertaken at the time of the injury: _____

Physical location (area) where injury occurred: _____

Type of injury (eg. Bruise, cut, fracture, grit in eye): _____

Part of body injured (eg. Arm, torso, head): _____

Cause of injury (what happened): _____

Treatment given/ Action taken: _____

Person Completing this Form

Surname: _____ Given Name(s): _____ Signature: _____

Date: _____ Time: _____ am/pm

Did the person cease work? Yes No

Has a referral for further treatment been issued? Yes No