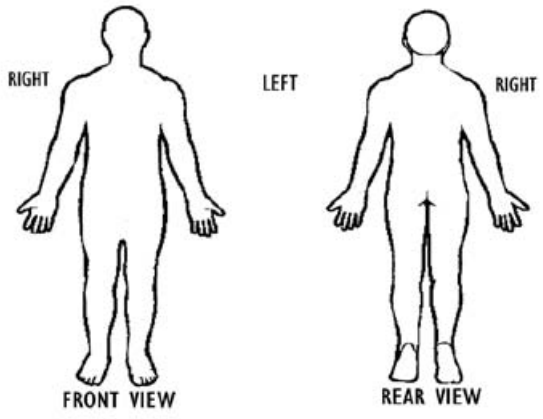
WHS FORM 10: INCIDENT AND INJURY REPORT

Details of injury (eg to a worker or visitor) and treatment			
Date of incident			
Time of incident	am ☐ pm ☐		
Nature of incident	☐ Near miss ☐ First aid ☐ Medical treatment/doctor		
Name of injured person			
Address			
Occupation			
Date of birth			
Telephone			
Employer			
Activity in which the person was engaged at the time of injury			
Exact site location where injury occurred			
Nature of injury – eg fracture, burn, sprain, foreign body in eye			
Body location of injury (indicate location of injury on the diagram)			
Treatment given on site		Name of treating person	
Referral for further treatment? Yes ☐ No ☐	Name of doctor or hospital	WorkCover medical certificate received? Yes ☐ No ☐	Attach copies
Injury management requirement? Yes ☐ No ☐	Notify return to work coordinator	Name of return to work coordinator	

Witness to incident (each witness may need to provide an account of what happened)			
Witness name		Witness contact	
Witness name		Witness contact	

Details of incident (eg property, plant or environmental damage)			
Date of incident		Time of incident	am ☐ pm ☐
Location of incident			
Details of damage to equipment or property			
Name of person who received the report		Telephone	

Description of incident

Immediate response actions (eg barricades, isolation of power) to stabilise the situation

Reported to	
Reported to principal contractor? Yes ☐ No ☐	Provide details (when, reported to and reported by):
Reported to authorities (WorkCover phone: **13 10 50**)? Yes ☐ No ☐	Provide details (when, reported to and reported by):
Reported to principal contractor? Yes ☐ No ☐	Provide details (when, reported to and reported by):
Reported to workers compensation insurer? Yes ☐ No ☐	Provide details (name of insurer and claim number):

Completed by			
Name		Position	
Signature		Date	