**WHS FORM 10: INCIDENT AND INJURY REPORT**

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| **Details of incident (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 medicalcertificate received?Yes [ ]  No [ ]   |  Attach copies |
|  Injury management  required? Yes [ ]  No[ ]   |  Notify return to work coordinator | Name of return to workCoordinator  |  |
|  **Witness to incident (each witness may need to provide an account of what happened)** |
| Witness name |  | Witness contact |  |
| Witness name |  | Witness contact |  |

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|  **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 Telephone  Received the report |

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| **Description of incident**  |
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| **Immediate response actions (eg barricades, isolation of power) to stabilise the situation**  |
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| **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 compensationinsurer?Yes [ ]  No [ ]  | Provide details (when, reported to and reported by):  |

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| **Completed by** |
| Name |  | Position |  |
| Signature |  | Date |  |