**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 medical  certificate received?  Yes  No | | Attach copies |
| Injury management  required?  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 |  | |

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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 compensation  insurer?  Yes  No | Provide details (when, reported to and reported by): |

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