

Incident Log Report

Employer name:		Address:	
Details of injured person:			
First Name:	Surname:		
Address:		Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/>
		Phone:	
DOB:		Mobile:	
What caused the accident?			
What happened?			
Time and date of accident:			
Nature of work injury or work caused illness?			
Medical treatment required:	<input type="checkbox"/> First Aid <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital	Admitted to: Name the Hospital	
Mechanism of injury/disease:	<input type="checkbox"/> heat radiation <input type="checkbox"/> electrocution <input type="checkbox"/> disease <input type="checkbox"/> sound & pressure	<input type="checkbox"/> biological factors <input type="checkbox"/> psychological factor <input type="checkbox"/> chemicals	<input type="checkbox"/> trip, fall <input type="checkbox"/> other Specify other:
Level of injury:	<input type="checkbox"/> minor injury <input type="checkbox"/> serious injury	<input type="checkbox"/> death <input type="checkbox"/> work caused illness	Worksafe notified? <input type="checkbox"/> Yes <input type="checkbox"/> No
Type of employment	<input type="checkbox"/> full time <input type="checkbox"/> part time <input type="checkbox"/> casual <input type="checkbox"/> other	Basis of employment: Occupation:	<input type="checkbox"/> Administration <input type="checkbox"/> Tradesperson <input type="checkbox"/> Apprentice/trainee <input type="checkbox"/> Other
Name of OHS representative :	Name:	Name and signature of person completing this report:	Name:
Date report completed:	Date:		Signature:
Employer contact:		Employer principal contact signature:	
Supervisors report:	Date:		
Managers report:	Date:		

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