

## Accident / Incident Report Form

This form should be completed by any employee or student who has experienced an accident or incident. For Employees, this is not a workers compensation claim form, however it is the first step towards making a workers compensation claim.

### SECTION 1 - DETAILS OF THE PERSON INJURED OR INVOLVED

<b>Title:</b>	Mr / Ms / Mrs / Miss / Dr (please circle)
<b>Surname:</b>	
<b>Given Names:</b>	
<b>Date of Birth:</b>	
<b>Employee Status</b>	Fulltime / Part Time / Casual (please circle)
<b>Home Address:</b>	
<b>Telephone:</b>	Home: _____ Work: _____ Mobile: _____
<b>Email:</b>	
<b>Position:</b>	
<b>Supervisor:</b>	
<b>Contact No:</b>	

### SECTION 2 - DETAILS OF THE ACCIDENT/INCIDENT

<b>Day, Date and Time of Incident:</b>	
<b>Location</b> (include address, building & room number if applicable):	
Describe what you were doing at the time of the incident:	
<b>What actually happened and what caused the incident? Include:</b> a) what action was involved (eg fall, struck by moving object) b) what object/machine/substance was involved (eg petrol fumes, wooden door frame)	
<b>Name and address of witness(es) to the accident:</b>	

**SECTION 3 - DETAILS OF THE HAZARD**

Where is the hazard(s) that contributed to the accident/injury?	
Was the hazard previously reported as a Hazard?	Yes / No    If Yes, when was the hazard reported:
If previously reported, was the Hazard resolved?	Yes / No

**SECTION 4 – DETAILS OF THE RESULTING INJURY/ILLNESS**

Describe the most serious injury or disease caused by the incident (eg fracture, cut, burn)	
Describe the body location of the injury or disease (eg upper arm, ankle eye)	
Any further details:	
When was medical attention sought for the injury/illness?	
Who provided the medical treatment?	
Do you require information pertaining to workers compensation:	Yes / No

**SIGNATURE OF PERSON INJURED / INVOLVED\***

Name \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

\* In instances where the person involved is unable to complete the form due to serious injury – a family member or associate may complete, sign and submit the form on his/her behalf.

**SIGNATURE OF SUPERVISOR**

Name \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

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This form should be completed as soon after the accident/incident as possible and submitted to the Director of Finance and Administration.