ACCIDENT REPORT

DATE:

Full name and address	
Telephone contact	
Date and time the incident occurred	
Date and time onset of symptoms occurred (if applicable)	
Incident location and description of location	
Names and contact details of witnesses	
Describe how the incident occurred and any contributing factors	
Details of injury/ injuries received	
Did you receive First Aid and if so, give name of administrator?	
Did you see a doctor or go to a hospital? Please give name and contact details.	
Date and time of visit/s	
Details of treatment and work status	

ACCIDENT REPORT

I approve the release of information in this form to approved authorities including medical practitioners, legal representatives, employee associations, insurance companies and WorkCover.

Signature: _____ Date: _____

OFFICE USE ONLY Action taken/ proposed to prevent recurrence of same or similar incident	