



Incident/Accident - Register of Injuries

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Authorised: Group Human Resources & Compliance Manager

Injured worker details

Family name:		First name:	
Position:		Department/team:	
Manager/supervisor's name:			

Injury/illness details

Date of injury/illness:		Time of injury/illness:		am/pm
Nature of injury/illness				
Bodily location of injury/illness				
Exaction location at time of injury				
Describe how the injury/illness was sustained				
Was any equipment involved in the injury/illness?			Yes / No (Please circle your response)	
<i>If yes, please provide details:</i>				

Witnesses

Were there any witnesses to the injury/illness? Yes / No (Please circle your response)

If yes, please list the witnesses' full names as well as a contact number for each.

Follow up

Was the injury reported to the worker's supervisor? Yes / No (Please circle your response)

Was any treatment provided? Yes / No (Please circle your response)

If yes, please provide details.

Did the injured worker return to work following the injury? Yes / No (Please circle your response)

If yes, please provide details.

Details of person making this entry

Family name: _____ First name: _____

Position: _____ Department/section: _____

Signature: _____ Date: _____

If you are not the injured worker, did you witness the injury/illness? Yes / No (Please circle your response)

To be completed by manager/supervisor of injured worker

Has an investigation been conducted into the incident? Yes / No (Please circle your response)

What, if any, controls were implemented to ensure the incident doesn't happen again?

Employer confirmation

I, _____ (print name), of _____
(insert company name),

hereby confirm receipt of this notification.

Signature: _____ Date: _____