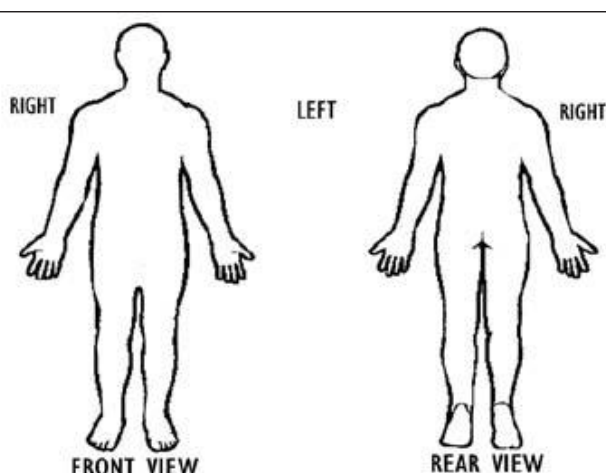


WHS FORM 10: HAZARD, INCIDENT AND INJURY REPORT

Details of incident (eg to a worker or visitor) and treatment			
Date of incident			
Time of incident	<input type="checkbox"/> am <input type="checkbox"/> pm		
Nature of incident	<input type="checkbox"/> Near miss <input type="checkbox"/> First aid <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>	Name of doctor or hospital	WorkCover medical certificate received? Yes <input type="checkbox"/> No <input type="checkbox"/>	Attach copies

Details of incident (eg property, plant or environmental damage)			
Date of incident		Time of incident	<input type="checkbox"/> am <input type="checkbox"/> pm
Location of incident			
Details of damage to Equipment or property			
Name of person who Received the report		Telephone	
Injury management required? Yes <input type="checkbox"/> No <input type="checkbox"/>	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	
Description of incident			
Immediate response actions (eg barricades, isolation of power) to stabilise the situation			
Reported to			
Reported to principal contractor? Yes <input type="checkbox"/> No <input type="checkbox"/>	Provide details (when, reported to and reported by):		
Reported to authorities (WorkCover phone: 13 10 50)? Yes <input type="checkbox"/> No <input type="checkbox"/>	Provide details (when, reported to and reported by):		

Reported to principal contractor? Yes <input type="checkbox"/> No <input type="checkbox"/>	Provide details (when, reported to and reported by):
Reported to workers compensation insurer? Yes <input type="checkbox"/> No <input type="checkbox"/>	Provide details (when, reported to and reported by):

Completed by			
Name		Position	
Signature		Date	

Please return this form when completed to your line manager and the Workplace Health & Safety Officer