

REGISTER OF INJURY



Employee Particulars

Name:	Employee No:
Address:	Supervisor:
Date of Birth:	Occupation:
Sex:	

Particulars of Incident

Date of Incident:	Time of Incident:	am <input type="checkbox"/>	pm <input type="checkbox"/>	Date injury notified:
Location at time of Incident:				
Description of Incident:				
Were there any witnesses to the incident:				
		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Name:		Phone:		
Name:		Phone:		
Did you sustain an injury as a result of the incident:				
		Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Particulars of Injury

Nature of Injury:				
Part/s of body injured:				
Did you require treatment/first aid:				
		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Treatment given by:				
Details of treatment:				
Did the worker return to work after the treatment: Yes <input type="checkbox"/> No <input type="checkbox"/> If no, initiate RTW procedures				
		Normal Duties <input type="checkbox"/>	Alternative Duties <input type="checkbox"/>	

Name of person making entry:	
Relationship to injured person:	
Signature:	Date:

Employer Acknowledgement

Name:	Signature:		
Position:	Date:		
Victorian WorkCover Authority Notification Required:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
To whom:	Date:	Time:	