Form No:	**CF-073**	
Form Name:	**Incident Report Form**	

AREA OF SERVICE- INCIDENT REPORT FORM

Section 1: Injured person's details	
Name of person/ s involved:	
Address:	
Phone Number(s):	
Date of birth:	**Male/Female:**
Who was person/s involved? (please circle one) Employee / Training Consultant / *Student*	

Section 2: Details of Accident / Incident	
Date of incident:	**Time of incident:**
Type of incident:	
Bodily location of incident:	
Describe how the injury was sustained:	
Do injuries require doctors or hospital visit? Yes / No (please circle your response)	
***If yes*, Name of Doctors / Hospital:** **Address:**	

Form No:	**CF-073**	
Form Name:	**Incident Report Form**	

Doctor/hospital phone number:

Section 3: Witnesses
Were there any witnesses to the accident / injury? Yes / No (please circle your response)
If yes, please list the witness's full name and contact number.

Section 4: 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.

Section 5: Details of person making this entry

Form No:	**CF-073**	
Form Name:	**Incident Report Form**	

Family name:	**First name:**
Position:	**Department/section:**
Signature:	**Date:**
If you are not the injured worker, did you witness the accident / Injury? Yes / No (please circle)	

Section 6: 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?

Section 7: Employer confirmation

I, _____ (print name), of

_____ (Insert company name),

hereby confirm receipt of this notification.

Signature: Date:

_____ _____

Requirements of injury notification:

Form No:	**CF-073**	
Form Name:	**Incident Report Form**	

- The RTO maintains a register of injuries at workplace for employees to record any workplace injury or illness
- You (or someone acting on your behalf) must notify us in writing of any work-related injury or illness within 30 days of becoming aware of the injury or illness
- The RTO will provide written confirmation to you upon notification of the injury or illness
- The RTO will provide a signed and dated copy of this entry to you.
- To make a Work safe claim you must complete a *Worker's Injury Claim Form*, available from the Australia Post.