	FOR WHS - 001	**Version: 1:0**
	Incident / Accident Report with Injury	Issued:20/10/2016 Next Review: 20/10/2017

This form is to be completed when an accident causing injury occurs in the workplace. This form can be completed by the worker involved or a witness or supervisor. If more than one person is injured a separate form for each person is to be used.	
Location of the accident:	
Date:	Time:
This accident caused: Death Serious injury Minor injury	
Details of the accident (what happened) …… …… …… …… …… …… …… …… …… ……	
Name of the injured person:	
Usual workplace of the injured person:	
Did the injured person need treatment at a hospital or clinic? Yes No	
Was the injured person admitted to the hospital or clinic? Yes No	
Describe the injuries (what is wrong with the person) …… …… ……	
Has the family of the injured person been notified? Yes No	
Were there any witnesses to the accident? Yes No	
Name of Witness 1	Phone:
Name of witness 2	Phone:
Has the WHS Coordinator been informed? (0458009429) Yes No	
Name of the person completing this form: What is your relationship to the injured person? Your contact details:	
Date WHS Coordinator received this form	