



Workplace Incident / Injury / Illness Report Form

USE THIS FORM TO REPORT ALL WORKPLACE INCIDENTS, INJURIES AND WORK-RELATED ILLNESSES WHETHER OR NOT THEY RESULT IN TIME OFF WORK. NEAR MISSES INCLUDED. ALL REPORTS ARE TO BE ADVISED OF ASAP – TO YOUR SUPERVISOR AND / OR BLH HSE MANAGER (0409429099).

DETAILS OF INJURED PERSON		
Name:		Payroll No:
Address:		Phone:
Dept:	Section:	
Location:		
Supervisor:	Phone:	
DETAILS OF INJURY / ILLNESS		
Part/s of body injured:		Nature of injury:
ACCIDENT DETAILS		
Location of accident:		
Date of accident:	Time	: am /pm
Time on duty at time of accident	hrs.	min. First Aid: Y/N By who:
Treatment: Doctor/medical centre/hospital/other:		
REPORTING OF INCIDENT		
Person reported to:		Position:
Date accident reported:	Time Reported :	
Report to Statutory authority?		Name of Department:
Reported to:		Position:
Office location:	Ph.	Date / /
DESCRIPTION OF INCIDENT		
How did the injury occur?		
Witnesses:		
Name:	Address:	Ph.
Name:	Address:	Ph.
INVESTIGATION (HSE Manager or delegate use only)		
Incident investigated by:	Position:	Ph.
Direct cause/s:		
Contributing factors:		
CORRECTIVE ACTIONS (HSE Manager or delegate use only)		
Corrective actions recommended:		
1.		
2.		
3.		Date / /
Corrective actions implemented:		
1.		
2.		
3.		Date / /
Further action required? Yes /No If Yes – attach separate report if required.		
Name:	Signature:	Date / /