



### Workplace Incident / Injury / Illness Statement

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Location: \_\_\_\_\_ Position: \_\_\_\_\_  
Section: \_\_\_\_\_ Phone / Contact: \_\_\_\_\_  
Date: \_\_\_\_\_ Supervisor: \_\_\_\_\_

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*Description of Incident / Injury / Illness*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Note: Attach separate page if required.

*Cause of the Incident / Injury / illness*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*How could the Incident / Injury / Illness have been prevented?*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Diagrams / sketches attached? – Y/N      If Yes – attach separate page

Witness Signed: \_\_\_\_\_ Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Interviewer Signed: \_\_\_\_\_ Name: \_\_\_\_\_ Date: \_\_\_\_\_

**THIS STATEMENT IS TO BE ATTACHED TO INCIDENT REPORT**