FIRST AID REPORT

Name: _____ **Date of Injury :** ____ / ____ / _____

Location of Accident: _____

Injured person's description of how injury occurred: _____

_____

_____

_____

_____

Description of injuries and condition: _____

_____

_____

_____

_____

Observations:

Time .....

Pulse .....

Breathing .....

Skin .....

Conscious .....

❒ Fracture ❒ Laceration

❒ Haemorrhage ❒ Burn

❒ Pain ❒ Swelling

❒ Other:.....

Description of Treatment given: _____

_____

_____

_____

_____ _____Date of Treatment: ____ / ____ / _____

Outcome:

❒ Return to work ❒ Home ❒ Medical Clinic ❒ Hospital ❒Own Car

❒ Staff Car ❒ Taxi ❒ Ambulance ❒ Report to Management/Supervisor

First Aid Officer:_____ Date: _____

PERSONAL INJURY REPORT

This report MUST BE COMPLETED for all injuries, no matter how minor. ALL parts of this report must be completed.

Name of person completing this report ..... Date .....

Name of injured person .....

Date of injury..... Time of injury .....

The injury was reported to ..... Date & time reported .....

Name of witness(es) .....

Describe how injury occurred .....

.....

.....

.....

Describe injury .....

Was this injury caused by manual handling activities: Yes / No

Was this injury caused by the action of another person: Yes / No If yes :

Name of person ..... Details .....

Was this injury caused by anything which was unsafe: Yes / No If yes :

Details .....

Were you aware of this unsafe situation/s: Yes / No If yes :

Reported to who..... Date and time seen .....

If unsafe why did you work on.....

Have you seen a doctor: Yes / No If yes :

What has the Doctor told you about the injury? .....

.....

What has the Doctor advised you to do about the injury? .....

.....

Has this injury occurred before Yes / No If yes: Date(s) of previous injury? .....

Give details .....

Have you ever had any problem in this area of the body or similar injury before:

Yes / No If yes:

Give details .....

I the injured person declare that the above information is true and correct.

Signed ..... *Date*.....

ACCIDENT INVESTIGATION

PARTICULARS OF ACCIDENT			
Date of accident			

THE INJURED PERSON				
Name:			Address:	
Age:	Phone number:			
Date of Accident			Length of employment a - at plant on job	
	❑ Bruising	❑Dislocation	❑ Other (specify)	Injured part of body
❑ Strains / sprain	❑ Scratch / abrasion	❑Internal		
❑ Fracture	❑ Amputation	❑Foreign Body	Remarks	
❑ Laceration / cut	❑ Burn scald	❑Chemical reaction		

DAMAGED PROPERTY	
Property / material damaged	Nature of damage
	Object / substance inflicting damage

THE ACCIDENT				
DESCRIPTION	Describe what happened (space overleaf for diagram – essential for all vehicle accidents)			
ANALYSIS	What were the causes of the accident?			
HOW BAD COULD IT HAVE BEEN? ❑ Very serious ❑ Serious ❑ Minor		WHAT IS THE CHANCE OF THIS HAPPENING AGAIN? ❑ Frequent ❑Occasional ❑ Rare		
PREVENTION	What action has or will be taken to prevent a recurrence? Use space overleaf if required. Tick items already actioned?		By Whom	When

TREATMENT AND INVESTIGATION OF ACCIDENT			
Type of treatment given	Name of person giving first aid	Doctor / Hospital	
Accident investigated by	Date	OSH advised YES / NO	Date

Incident / Accident Register

Report No	Date	Injury	Cause	Corrective action	Date	Review date

RETURN TO WORK PLAN

The following return to work (RTW) plan has been developed for:				
Worker:			Claim No.	
Employer:				
1.	Job Title – pre injury:		Suitable Duties:	
2.	Work Location:			
3.	Supervisor:			
4.	Duties to be performed		Duties to avoid	
☐			☐	
☐			☐	
☐			☐	
☐			☐	
☐			☐	
☐			☐	
☐			☐	
☐			☐	
Specific duties to be avoided:				
5.	Hours/days of the week:			
	Week 1.		Week 2.	
6.	Wages, Award (if applicable)			
7.	Plan commencement date:		Length of plan:	
8.	Review dates:			
9.	Expected return to pre-injury duties date:			
10.	Current medical certificate: From:		To:	Partial/total inc
11.	Restrictions:			
12.	Considerations:			
13.	General comments:			

The following parties have agreed to this plan:			
Print Name		Signature:	Telephone Number
	Injured Worker		
	Supervisor		
	Rehabilitation Coordinator		
	Nominated Treating Doctor		
	Dated:		
PLEASE FAX URGENLY TO: ……- INJURY MANAGEMENT DEPARTMENT: …… CLAIMS: ……			

MOTOR VEHICLE / TRUCK ACCIDENT REPORT FORM (1.)

Insured

Name:.....

Address:.....

Employer:.....

Employers address:.....

Private Phone:.....

Business Phone:.....

Driver

Name:.....

Address:.....

Age:..... Licence No:..... Exp:.....

Vehicle

Year/Make/Model:.....

Registration:.....

Alcohol

Did you consume any alcohol or take any drugs 12 hours prior to the accident:

.....

Did you undergo a breath or blood test or analysis?.....

If so, what was the result:.....

Accident

Date:..... Hour:..... AM or PM: .....

Where did it occur?.....

Weather at time of accident: .....

Was this accident report to Police? .....

Police Station:.....

Who do Police consider responsible for accident:.....

Name of Police Officer and number:.....

Driver of Other Vehicle

Name:.....

Address:.....

Age:..... Licence No:..... Exp:.....

Name of registered owner: .....

Address:..... Telephone number:.....

MOTOR VEHICLE / TRUCK ACCIDENT REPORT FORM (2.)

Registration No: ..... Make of vehicle: .....

Name of Insurance Co: .....

Description of Accident

How accident occurred: .....

.....

.....

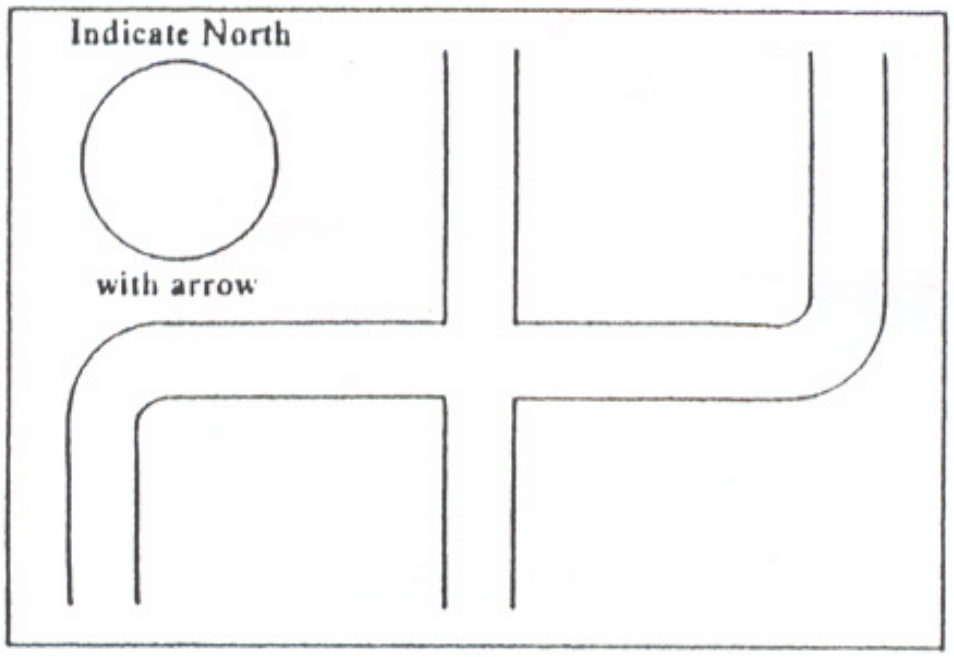
.....

.....

.....

.....

Diagram of Accident



Witness

Name: ..... Age: .....

Address: .....

I declare that the above particulars are true in every respect.

Signature of driver: .....

Date: .....

MOTOR VEHICLE / TRUCK ACCIDENT REPORT FORM (3.)

INJURIES SUSTAINED REPORT FORM

OUR DRIVER

Medical Examination required? .....YES / NO

Name of Doctor: .....

Address: .....

Hospitalisation required? .....YES / NO

Name of Hospital: .....

Address: .....

OUR PASSENGER

Medical Examination required? .....YES / NO

Name of Doctor: .....

Address: .....

Hospitalisation required? .....YES / NO

Name of Hospital: .....

Address: .....

OTHER VEHICLE DRIVER

Medical Examination required? .....YES / NO

Name of Doctor: .....

Address: .....

Hospitalisation required? .....YES / NO

Name of Hospital: .....

Address: .....

OTHER VEHICLE PASSENGER

Medical Examination required? .....YES / NO

Name of Doctor: .....

Address: .....

Hospitalisation required? .....YES / NO

Name of Hospital: .....

Address: .....