

WHS FORM 10: INCIDENT AND INJURY REPORT

| Details of injury (eg to a worker or visitor) and treatment | | | |
|---|---|--|---|
| Date of incident | | Time of incident | am <input type="checkbox"/> pm <input type="checkbox"/> |
| Nature of incident | <input type="checkbox"/> Near miss <input type="checkbox"/> First aid <input type="checkbox"/> Medical treatment/doctor | | |
| Name of injured person | | | |
| Address | | | |
| Occupation | | | |
| Date of birth | | | |
| Telephone | | | |
| Employer | | | |
| Activity in which the person was engaged at the time of injury | | | |
| Exact site location where injury occurred | | | |
| Nature of injury – eg fracture, burn, sprain, foreign body in eye | | | |
| Body location of injury (indicate location of injury on the diagram) | | | |
| Treatment given on site | | Name of treating person | |
| Referral for further treatment? Yes <input type="checkbox"/> No <input type="checkbox"/> | Name of doctor or hospital | SafeWork NSW medical certificate received? Yes <input type="checkbox"/> No <input type="checkbox"/> | Attach copies |
| Injury management requirement? Yes <input type="checkbox"/> No <input type="checkbox"/> | Notify return to work coordinator | Name of return to work coordinator | |

| Witness to incident (each witness may need to provide an account of what happened) | | | |
|--|--|-----------------|--|
| Witness name | | Witness contact | |
| Witness name | | Witness contact | |

