

8.13.1 Employee Injury, Accident, Incident and Illness Record

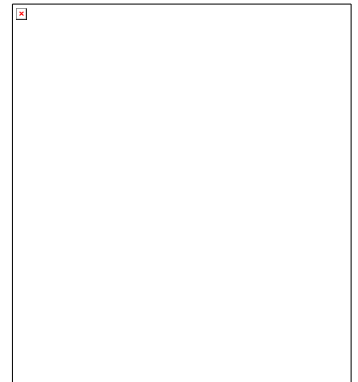
Employee name: _____ Time: _____ Date: _____

Details of accident: _____

Details of injury/trauma:

- | | | | |
|---------------------------------|--|-----------------------------------|-------------------------------|
| <input type="checkbox"/> Cut | <input type="checkbox"/> Abrasion/scrape | <input type="checkbox"/> Bruise | <input type="checkbox"/> Bite |
| <input type="checkbox"/> Sprain | <input type="checkbox"/> Break/fracture | <input type="checkbox"/> Swelling | <input type="checkbox"/> Burn |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Concussion | | |

(Indicate area on diagram)



Details of action taken including first aid and/or administration of medications _____

Medical advice sought: ☐ NO ☐ YES details: _____

Treatment: _____

Other comments/witnesses: _____

Staff member signature: _____

Coordinator name and signature: _____

Workcover claim submitted: ☐ NO ☐ YES

It is essential for the safety and wellbeing of employees that all accidents be accurately documented for future reference. Copies of any Workcover documentation should be attached to this form.

Office of Industrial Relations - Form 3

Incident notification form

https://www.worksafe.qld.gov.au/data/assets/pdf_file/0020/82505/incidents_form.pdf

DATE DEVELOPED	DATE RATIFIED	DATE REVIEWED	DATE RATIFIED
August 2018	August 2018	23.06.2021	October 2021
		09.04.2024	April 2024