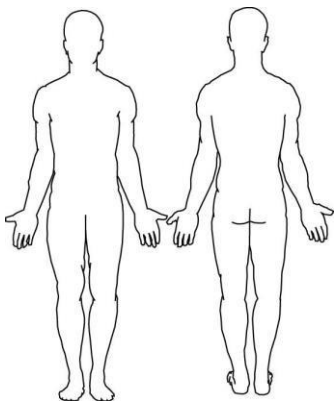


<p>Primary Injury or Disease: (Tick Primary injury. If more than one, tick Multiple Injuries)</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Strain/Sprain - Pain Gradual</td> <td><input type="checkbox"/> Burns</td> </tr> <tr> <td><input type="checkbox"/> Strain/Sprain - Pain Sudden</td> <td><input type="checkbox"/> Dermatitis</td> </tr> <tr> <td><input type="checkbox"/> Cut / Open Wound</td> <td><input type="checkbox"/> Chemical Exposure</td> </tr> <tr> <td><input type="checkbox"/> Bruising</td> <td><input type="checkbox"/> Poisoning</td> </tr> <tr> <td><input type="checkbox"/> Crushing</td> <td><input type="checkbox"/> Electrocution</td> </tr> <tr> <td><input type="checkbox"/> Dislocation</td> <td><input type="checkbox"/> Concussion</td> </tr> <tr> <td><input type="checkbox"/> Fracture</td> <td><input type="checkbox"/> Impact Injury</td> </tr> <tr> <td><input type="checkbox"/> Fatigue</td> <td><input type="checkbox"/> Foreign Body</td> </tr> <tr> <td><input type="checkbox"/> Acute Hearing Loss</td> <td><input type="checkbox"/> Breathing Difficulties</td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td><input type="checkbox"/> Multiple Injuries</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Infectious /Parasitic Disease: _____</td> </tr> </table> <p>I was injured by: (Mechanism of Injury -Tick one)</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Slip /Trip / Fall</td> <td><input type="checkbox"/> Sound / Pressure</td> </tr> <tr> <td><input type="checkbox"/> Body Stressing</td> <td><input type="checkbox"/> Biological Factors</td> </tr> <tr> <td><input type="checkbox"/> Heat / Radiation / Energy</td> <td><input type="checkbox"/> Mental Stress</td> </tr> <tr> <td><input type="checkbox"/> Hitting object with body</td> <td><input type="checkbox"/> Fatigue</td> </tr> <tr> <td><input type="checkbox"/> Chemicals / other Substance</td> <td><input type="checkbox"/> Moving object</td> </tr> </table>	<input type="checkbox"/> Strain/Sprain - Pain Gradual	<input type="checkbox"/> Burns	<input type="checkbox"/> Strain/Sprain - Pain Sudden	<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Cut / Open Wound	<input type="checkbox"/> Chemical Exposure	<input type="checkbox"/> Bruising	<input type="checkbox"/> Poisoning	<input type="checkbox"/> Crushing	<input type="checkbox"/> Electrocution	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Concussion	<input type="checkbox"/> Fracture	<input type="checkbox"/> Impact Injury	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Foreign Body	<input type="checkbox"/> Acute Hearing Loss	<input type="checkbox"/> Breathing Difficulties	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Multiple Injuries	<input type="checkbox"/> Infectious /Parasitic Disease: _____		<input type="checkbox"/> Slip /Trip / Fall	<input type="checkbox"/> Sound / Pressure	<input type="checkbox"/> Body Stressing	<input type="checkbox"/> Biological Factors	<input type="checkbox"/> Heat / Radiation / Energy	<input type="checkbox"/> Mental Stress	<input type="checkbox"/> Hitting object with body	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Chemicals / other Substance	<input type="checkbox"/> Moving object	<p>CAUSE OF HARM Which of these injured or potentially injured me? (Tick one)</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Machinery / Fixed Plant</td> <td><input type="checkbox"/> Chemical</td> </tr> <tr> <td><input type="checkbox"/> Mobile Plant / Machinery</td> <td><input type="checkbox"/> Material</td> </tr> <tr> <td><input type="checkbox"/> Powered Equipment / Tool / Appliance</td> <td><input type="checkbox"/> Substance</td> </tr> <tr> <td><input type="checkbox"/> Biological</td> <td><input type="checkbox"/> Animal / Human</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Non-powered Tool / Appliance / Equipment</td> </tr> </table> <p>Circle where the injury is located on your body:</p> <div style="text-align: center; margin-top: 20px;">  </div>	<input type="checkbox"/> Machinery / Fixed Plant	<input type="checkbox"/> Chemical	<input type="checkbox"/> Mobile Plant / Machinery	<input type="checkbox"/> Material	<input type="checkbox"/> Powered Equipment / Tool / Appliance	<input type="checkbox"/> Substance	<input type="checkbox"/> Biological	<input type="checkbox"/> Animal / Human	<input type="checkbox"/> Non-powered Tool / Appliance / Equipment	
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Details of other persons involved		
Did the incident involve any other person or witness?	<input type="radio"/> Yes	<input type="radio"/> No
	If yes, was the other person injured?	
If yes, please provide contact details:		
Other details (Management to complete this section)		
Did any damage to property occur?	<input type="radio"/> Yes	<input type="radio"/> No
<i>(If yes, provide details of the damage)</i>		
Were the Police involved?	<input type="radio"/> Yes	<input type="radio"/> No
<i>(If yes, provide details of the officers attending)</i>		
Was the regulator (e.g. WorkSafe) informed?*	<input type="radio"/> Yes	<input type="radio"/> No
Is this an accident compensation related incident?	<input type="radio"/> Yes	<input type="radio"/> No

*WorkSafe *must* be informed of a notifiable illness, injury or a notifiable event occurring in the workplace.

Your Name: _____
Person Reporting Event

Signature: _____
Person Reporting Event

Date: _____

Manager's Name: _____

Manager's Signature: _____

Date: _____