

INJURY AND INCIDENT INVESTIGATION FORM



COMPANY NAME :

ADDRESS :

NAME OF INDIVIDUAL INVOLVED:

ADDRESS :

PHONE NUMBER:

DATE OF BIRTH:

JOB / ROLE DESCRIPTION:

INCIDENT TYPE :

NEAR-HIT/NEAR MISS

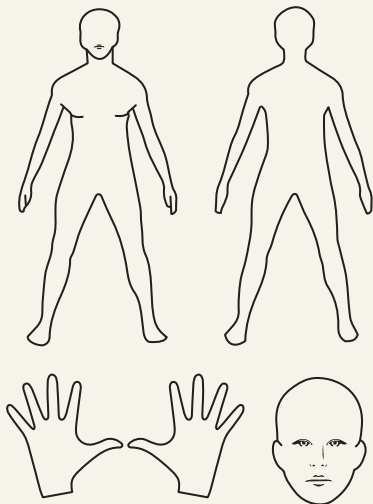
INJURY

ILLNESS

DATE OF INCIDENT :

TIME OF INCIDENT

INJURY DETAILS - BODY PART/S SHADE AREAS INJURED



INJURY TYPE (TICK)

- ACHES/PAIN (GRADUAL)
- ACHES/PAIN (SUDDEN)
- AMPUTATION
- BROKEN BONE
- BRUISING INCL. CRUSHING
- BURN/SCALD
- CHEMICAL REACTION
- CHOKING/SUFFOCATION
- CONCUSSION/BRAIN INJURY
- CUT (INFECTED)
- CUT (NOT INFECTED)
- DENTAL INJURY
- DERMATITIS
- DISLOCATION
- FATAL
- FOREIGN BODY
 EYE NOSE EAR
- INHALATION DISEASE (ASBESTOS /LEAD)
- HEARING LOSS (NOISE INDUCED)
- POISONING
- STRAIN/SPRAIN
- OTHER
- MULTIPLE INJURIES

TREATMENT DETAILS (TICK)

- NONE FIRST AID NURSE PHYSIOTHERAPY DOCTOR HOSPITAL

WHAT HAPPENED?

WHAT DO YOU THINK CAUSED OR CONTRIBUTED TO THE INCIDENT?

EMPLOYEE SIGNATURE :

DATE :