## INJURY AND INCIDENT REPORT FORM

Please complete sections A, B & C within 24 hours and provide a copy to Manager, Equipment & Facility



## **SECTION A: INCIDENT DETAILS**

Incident reported by:

Incident Date:	Incident Time:	Where did the incident occur? Describe the exact address/location/room:			
Person Affected/Injured: Contact no: Occupation:		Person Affected Position:  Staff Student No. Staff Other Other			
□ Recess break eg I		to/from work on duty	Task Frequency:  □ Routine task □ Unusual Task		
Main Witness Name:			Main Witness P	Main Witness Phone Number:	
Incident and Injury I	Description:				
		•••••			
	'		Constitution Department	······································	
Incident Type: Please t	equired please complete the Attach tick □ Chemical	ment Furtner Incia	<ul> <li>ent and Injury Descript</li> <li>Motor Vehicle Acciden</li> </ul>		
□ Animal □ Biological	□ Computer/work s □ Heat, Radiation,		<ul><li>□ Near Miss</li><li>□ Needlestick/sharps</li></ul>	<ul><li>□ Slip/Trip/Fall</li><li>□ Struck by object</li></ul>	
□ Bumped into object	□ Manual Handling		□ Noise	□ Other:	
To be completed for an	IRED PERSON'S DETAIL ny injury to an employee, studer		Dete of l	2	
Name of Injured person	on:		Date of I	3irth:	
Residential address:					
Home Phone Number	r:	Work Phor	Work Phone Number:		
Mobile Phone Number		Email address:			
Injury Reported to:		Date reported:			
Initial treatment given	by:				
□ First Aid Officer (na	ame):	🗆 Ot	her (details)		

**Reporters Contact Number:** 

SECTION C: INJURED EMPLOYEE DECISION ON CLAIMING WORKERS COMPENSATION

For all injuries to employees please tick one of the following:

- □ NOTIFY AS A WHS INCIDENT ONLY:
  □ Notify at next WHSC meeting □ Further investigation required
- □ **NOTIFY AS A WORKERS COMPENSATION CLAIM:** I wish to lodge a claim for workers compensation for medical expenses and time off work associated with this injury or illness. Please complete Section D below.

## SECTION D: REQUIRED FOR EMPLOYEE TO BEGIN A CLAIM FOR WORKERS COMPENSATION

A NSW Workers Compensation Medical Certificate muclaims – by email to future@isasydney.com.au or by n	ail to 242 Young St, Waterloo NSW 2017.			
2. NSW legislation caps weekly compensation payments earn over the capped amount will incur a wage loss ur				
Employment Status: tick one	Date Commenced Employment:			
□ Full time □ Part time □ Casual				
Award Wage Rate per week (gross):	Award Hours per week:			
Average Weekly earnings: (for casual staff only)	Average Hours per week: (for casual staff only)			
Date Ceased work:	Time ceased work:			
Current work status: <i>tick one</i> □ Unfit for work □ Fit for pre injury duties □ Fit for suitable d	Date resumed work: Lost hours to date:			
Parts of Body Injured:				
Previous Related Injuries:	Marital Status:  □ Married □ De Facto □ Single Dependents:			
Treating Doctors Name:				
Doctors Address:				
Doctors Phone Number:	Doctors Fax Number:			
Treatment Program:				
Current Medical Certificate date:	Review date:			
Completed by:	Signature:			
Date:				
Blank Injury and Incident Report forms are available from ISA Sta	ff Office or via the ISA website.			

ISA Injury and Report Form Page 2 of 3

## **Attachment: Further Incident and Injury Description**

Incident and Injury Description:
incident and injury Description.