INCIDENT/ACCIDENT REPORT

ERAF603

Date: / /	Completed by:	No: *[office use only]*
Date Employer Notified: / /	Signed:	
Location:	*[Location of incident/accident. If journey occurrence, provide accident address]*	

Type:	Accident/Injury ○	Hazard Identification ○	Dangerous Occurrence ○	Near Miss ○

[Please tick ✓one only]

Description: *[what, how, why?]*

Injured Workers Details: *[if applicable]*		
Name:	Sex: Male ○ Female ○	Date of Birth: / /
Marital Status:	No. of Dependants:	Occupation:
Contact Phone Number:		
Date of Accident: / /	Time of Accident: am/pm	
Description of injury/body part injured:		

Treating Doctor details: *[if applicable]*	
Name:	
Address:	
Telephone Number:	Fax Number:
WorkCover Medical Certificate Issued:	No ○
	Yes ○ Expected Return to work Date: alternate duties / / or pre-injury duties / /

[Office use only]

Received By:	Principal Notified: / /	am/pm
Insurer First Notification: / / am/pm		
Action Taken:		
Date Closed: / /	By:	Signed: