Australian Technical College
WESTERN AUSTRALIA

Incident Report Form

Section 1 –Details of Injured Person			
Full Name:			
Contact Tel:		**Mobile:**	
Address:			
Email:			

Section 2 – Details of Incident			
Date of Incident:		**Time:**	___ ___ :___ ___ am/pm
Location of Incident:			
Reported to:		**Position Title:**	

Description of incident: (What and how the incident occurred)

Section 3 – Details of Injury and Treatment

Description of injury:

Treatment Provided:

☐ None Required

☐ First Aid (please describe)

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Treated by:

☐ Taken to Doctors Surgery (provide detail)

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☐ Taken to Hospital (provide detail)

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☐ Ambulance called and attended

Further Treatment Recommended:

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☐ None
☐ Other (please describe)

Section 4 – Witnesses to Incident

The following persons witnessed the incident:

Name 1:		**Contact:**	
Address:			
Signature 1:		**Date:**	/ /
Name 2:		**Contact:**	
Address:			
Signature 2:		**Date:**	/ /

Section 5 – Signatures

Supervisor :			
Signed:		**Position:**	
Print Name:		**Date:**	
First Aider :			
Signed:		**Position:**	
Print Name:		**Date:**	
Director :			
Signed:		**Position:**	
Print Name:		**Date:**	

Admin Use Only

Reported to Insurer :	☐ Yes	☐ No	**Date:**	/ /
Reported By:			**Signature:**	
Reported to Worksafe :	☐ Yes	☐ No	**Date:**	/ /
Reported By:			**Signature:**	