

 **CLINIC INCIDENT REPORT**

# Date of Incident Time of Incident

\_\_\_\_ / \_\_\_\_ / \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Personal Details of Injured

Name: Surname:

Address: Mobile:

Gender: Date of Birth:

Occupation:

# Details of person completing the incident report form

Name: Surname:

Position at workplace: Mobile:

Relationship to the injured person, i.e.: Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Incident Details

# What happened: Provide a brief overview of the incident

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# Where did the incident occur? (Provide the address and a detailed description of the specific location of the incident, i.e. Level 3 in the staff kitchen)

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# Provide a detailed description of the incident.

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Was first aid or further treatment required? [ ]  Yes [ ]  No

If yes, please provide a description of the injury and the treatment that was provided.

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Did the injured person require external medical treatment? [ ]  Yes [ ]  No

If yes, please provide details of where the person was taken for treatment including the name, address and contact details.

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Is this a ‘notifiable incident’? [ ]  Yes [ ]  No

*A ‘notifiable incident’ is:*

* *the death of a person*
* *a ‘serious injury or illness’, or*
* *a ‘dangerous incident’ arising out of the conduct of a business or undertaking at a workplace.*

Has the incident been reported to WorkSafe? [ ]  Yes [ ]  No

Were there any witnesses to the incident? [ ]  Yes [ ]  No

If yes, please provide their details:

Name: Surname:

Address: Mobile:

Date of Birth: Occupation:

Additional comments

Signature of person responsible for completing the incident report: