Injury Report Form

Use this form to report a workplace injury.

|  |  |  |  |
| --- | --- | --- | --- |
| Given name |  | Date of injury |  |
|  |  |
| Surname |  | Time of injury |  |
|  |  |
| Residential address |  | When did the injury occur? | [ ]  During work hours [ ]  Journey to/ from work[ ]  During work break [ ]  Other  |
|  |
| Postcode |  | Address where injury took place |  |
|  |  |
| Suburb |  |  |
|  |  |
| State |  | Provide details of the injury e.g. what happened? |  |
|  |  |
| Contact numbers | Home -  |  |
| Work - |  |
| Mobile - |  |
| Date of birth |  | Provide details of injury sustained e.g. which parts of your body are affected? |  |
| Employee Number |  |  |
| Gender | [ ]  Male [ ]  Female |  |
| Position held |  |  |
|  |  |
| Department/ Line of Business |  | Do you have any pre-existing injuries/ conditions? Is yes please provide details.  |  |
|  |  |
|  |  |
| Work address |  |  |
|  |  |
|  |  |
| Supervisor’s name |  | Action taken | [ ]  I received first aid treatment [ ]  I went to see a doctor[ ]  No action was taken[ ]  Other ……………………………………….. |
|  |
| Supervisor’s contact details |  |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Employment / engagement status | [ ]  I am a contractor/temp working for at a Hudson client worksite[ ]  I am a direct Hudson employee working at Hudson offices[ ]  Other …………………………………. | Name of doctor or hospital if you have sought treatment  |  |
|  |
|  |
| Name of your Hudson Consultant (only applicable if you are a contractor/ temp working at a Hudson client worksite) |  | Please provide details for any witnesses to the injury |  |
|  |  |
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| --- |
| What preventative measures have been taken or could be taken to prevent reoccurrence (if any)? |
|  |
| Please provide any other relevant details |
|  |

**Form completed by:**

**Date:**

**Next Steps**

Forward this completed form and any other relevant documentation to Safety@hudson.com