

**PARTICULARS OF INCIDENT**

Date of accident	Time	Location	Date reported

**THE INJURED PERSON**

Name	Address

Age	Phone number

Date of accident	Length of employment

<b>TYPE OF INJURY:</b>	<input type="checkbox"/> Bruising	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Injured part of body
<input type="checkbox"/> Strain/sprain	<input type="checkbox"/> Scratch/abrasion	<input type="checkbox"/> Internal	<input type="checkbox"/> Chemical Reaction	
<input type="checkbox"/> Fracture	<input type="checkbox"/> Amputation	<input type="checkbox"/> Foreign body		
<input type="checkbox"/> Laceration/cut	<input type="checkbox"/> Burn scald			

**DAMAGED PROPERTY**

Property/ material damaged	Nature of damage
	Object/substance inflicting damage

**THE ACCIDENT - DESCRIPTION**

Describe what happened (space overleaf for diagram — essential for all vehicle accidents)

**ANALYSIS**

What were the causes of the accident?

**HOW BAD COULD IT HAVE BEEN?**

**WHAT IS THE CHANCE OF IT HAPPENING AGAIN?**

<input type="checkbox"/> Very serious	<input type="checkbox"/> Serious	<input type="checkbox"/> Minor	<input type="checkbox"/> Minor	<input type="checkbox"/> Occasional	<input type="checkbox"/> Often
---------------------------------------	----------------------------------	--------------------------------	--------------------------------	-------------------------------------	--------------------------------

**PREVENTION**

What action has or will be taken to prevent a recurrence? Tick items already actioned	By whom	When

**TREATMENT AND INVESTIGATION OF ACCIDENT**

Type of treatment given	Name of person giving first aid	Doctor/Hospital

Accident investigated by	Date	Worksafe NZ advised YES /NO	Date