**STAFF ACCIDENT/ILLNESS/INCIDENT REPORT FORM**

**Staff are to use this form for any work related injury/illness/Incident/Near miss and forward it to the Nurse Manager as soon as practicable**

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| **I am reporting a work related:****(Please circle)** | **Injury** | **Illness** | **Near miss** | **Incident** |
| **Name:****Contact Number:****Address:** |  |
| **Job Title:** |  |
| **Establishment injury/illness took place:** |  |
| **Date injury/illness occurred:** |  |
| **Time injury/illness occurred:** |  |
| **Name of person injury/illness reported to at establishment:** |  |
| **Description of injury/illness (include any witnesses if appropriate)** | **(Please continue on the back of this form if necessary)** |
| **Actions taken:** |  |
| **Signed:****Print:****Date:** |  |
| **For Office Use Only** |  |
| **Date incident form received:** |  |
| **By whom:** |  |
| **Actions taken:** |  |
| **Occupational Health Referral required:** | **Yes/No (please indicate)** |
| **Staff member’s GP advised:****(Obtain Staff members permission)** | **Yes/No (please indicate)** |
| **Follow up required:****(If so, date of follow up)** | **Yes/No (please indicate)** |
| **Signed:****Print:****Date:****Job title:** |  |