

# INJURIES REGISTER

General			
Workplace location:			
Injured persons name:			
Home address:			
Date of birth:		Male <input type="checkbox"/>	Female <input type="checkbox"/>
Occupation:			
Employers name:			
Employers address:			
Details of Injury			
Date of Injury:		Time of injury	am <input type="checkbox"/> pm <input type="checkbox"/>
Activity in which the person was engaged at the time of injury:			
Exact location where injury occurred:			
Nature of injury:			
Body location of injury:			
Details of Treatment			
Treatment provided by First aid officer:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Remarks	
Follow up treatment required:	Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>If yes, an incident investigation report must be completed within 24hrs</i>	
Doctor / Medical Centre attended:			
Date attended:		Medical cert received	Yes <input type="checkbox"/> No <input type="checkbox"/>
Treatment:			
Further consultation required:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Injury management required	Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If yes, notify the RTW coordinator</i>
Name of witness:			
Address of witness:			
Name of person providing first aid			
Signature		Date:	