Insert Logo Here

Accident/Incident Notification

Worker or Workplace Participant to complete this form. If the accident or incident is to be reported to Worksafe NZ – this must be done within 48 hours.

Reporter Details

Name: _____

Role _____

Accident/Incident Details

Place of Accident/Incident:

Description:

Date Occurred: _____ Time: _____ Date Reported: _____ Time: _____

Work ceased (Y/N): _____ Date: _____ First Aid Required? Y/N _____

ACC Contacted(Y/N) _____ Medical Treatment required? Yes ☐ No ☐

Type of Incident	Nature of Injury	Part of the body injured
☐ Flying Object ☐ Struck by _____ ☐ Caught in _____ ☐ Manual Handling ☐ Poison ☐ Temperature ☐ Electricity ☐ Fall ☐ Other_____	☐ Sprain ☐ Fracture ☐ Multiple contusion ☐ Laceration ☐ Concussion ☐ Dislocation ☐ Burn ☐ Superficial ☐ Amputation ☐ Other: _____	☐ Neck ☐ Head ☐ Eyes ☐ Trunk ☐ Arm ☐ Leg ☐ Multiple ☐ General ☐ Unspecified

Nature and Extent of Injury:

Actions Taken: