

REGISTER OF INJURY

Rusher Rogers HR Solutions

Employee Particulars

| | |
|----------------|---------------|
| Name: | Employee No.: |
| Address : | Supervisor:: |
| Date of Birth: | Occupation: |
| Sex: | |

Particulars of Incident

| | | | |
|--|------------------------------|---|-----------------------|
| Date of Incident: | Time of incident: | am <input type="checkbox"/> pm <input type="checkbox"/> | Date injury notified: |
| Location at time of incident: | | | |
| Description of incident: | | | |
| | | | |
| | | | |
| Were there any witnesses to the incident: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Name: | | | Phone: |
| Name: | | | Phone: |
| Did you sustain an injury as a result of the incident: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |

Particulars of injury

| | | | |
|--|------------------------------|--|---|
| Nature of injury: | | | |
| Part/s of body injured: | | | |
| Did you require treatment/first aid: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Treatment given by: | | | |
| Details of treatment: | | | |
| | | | |
| Did the worker return to work after the treatment: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If no, initiate RTW procedures. |
| | | Normal Duties <input type="checkbox"/> | Alternative Duties <input type="checkbox"/> |

| | |
|---------------------------------|-------|
| Name of person making entry: | |
| Relationship to injured person: | |
| Signature: | Date: |

Employer Acknowledgment

| | | |
|---|------------------------------|-----------------------------|
| Name: | Signature | |
| Position: | Date: | |
| Victorian WorkCover Authority Notification Required | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| To whom | Date: | Time: |

Please note that this document may require a Privacy Statement. Please discuss with your company's legal representative.