

Section 2. Harm (if applicable)

Injured person

Name	<input type="text"/>	Date of Birth	<input type="text"/>
Contact Details	Phone: <input type="text"/>	Email:	<input type="text"/>
Residential address	<input type="text"/>		

Role or job title of injured person:

<input type="text"/>			
<input type="checkbox"/> Staff	<input type="checkbox"/> Student	<input type="checkbox"/> Other	Staff/Student ID No. <input type="text"/>
Gender: <input type="text"/>	Signature: <input type="text"/>	Date: <input type="text"/>	

Period of employment of injured person: (if applicable)

- 1st week
 1st month
 1-6 months
 6 months - 1 year
 1-5 years
 Over 5 years

Time at work prior to injury: (if applicable)

Started work at am / pm
 Incident occurred at am / pm
 Hours on shift hours

Treatment of injury:

- Nil
 First-aid
 Doctor/Emergency Dept. (not hospitalised)
 Hospitalised (admitted)

Where were they treated?

Location
 Doctor (if known)

What caused the injury? (Agency of harm)

- | | | |
|--|--|---|
| <input type="checkbox"/> Human factors (unsafe acts or behaviours) | <input type="checkbox"/> Animal, human or plant/vegetation (biological agency) | <input type="checkbox"/> Other biological factors (e.g. Bacterial or viral) |
| <input type="checkbox"/> Chemical or chemical products | <input type="checkbox"/> Environmental (e.g. heat, cold) | <input type="checkbox"/> Exposure (e.g. dust, gas, noise, etc.) |
| <input type="checkbox"/> Machinery or (mainly) fixed plant | <input type="checkbox"/> Material or substance | <input type="checkbox"/> Mobile plant or transport |
| <input type="checkbox"/> Powered equipment, tools or appliances | <input type="checkbox"/> Non-powered hand tool or equipment | <input type="checkbox"/> Other _____ |

Nature of injury or damage (Specify all):

- | | |
|---|--|
| <input type="checkbox"/> Abrasion/scratches | <input type="checkbox"/> Eye injury |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Foreign body |
| <input type="checkbox"/> Bruising/crushing | <input type="checkbox"/> Fracture |
| <input type="checkbox"/> Burn/scald | <input type="checkbox"/> Internal injury |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Laceration/cut |
| <input type="checkbox"/> Dislocation | <input type="checkbox"/> Sprain or strain |
| <input type="checkbox"/> Puncture wound | <input type="checkbox"/> Contamination/poisoning/toxic |
| <input type="checkbox"/> Reaction | <input type="checkbox"/> Occupational Hearing Loss |
| <input type="checkbox"/> Disease | <input type="checkbox"/> Gradual process/OOS or RSI |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Fatal |
| <input type="checkbox"/> Other _____ | |

Body part:

- | | | |
|---|------------------------------------|---|
| <input type="checkbox"/> Head | <input type="checkbox"/> Neck | <input type="checkbox"/> Trunk |
| <input type="checkbox"/> Arms/hands | <input type="checkbox"/> Legs/feet | <input type="checkbox"/> Multiple locations |
| <input type="checkbox"/> Systemic (internal organs) | | |

Side of Body:

- Left
 Right
 Not Applicable

Other (specify)

Description of Injury

(As much detail as possible)

E.G. : Crushed middle finger on left hand

Office use only – HSW Service Injury Claims Manager to complete

Do you accept this as a work related injury?
 Yes
 No
 Unsure
 Not applicable

I, the undersigned, declare that the details above have been completed accurately, truthfully and fully to the best of my knowledge and belief, and I understand that providing a false or misleading statement is an offence.

Signature of Injury Claims Manager:
 Date:

Section 3. Investigation

To be carried out by local line manager for accidents/incidents that are not notifiable. Note: The Health and Safety Representative can assist where necessary and it is good practice to do so.

For **Notifiable Events**, a formal investigation must be carried out in accordance with Worksafe NZ's instructions by the HSW Service.

Analysis of what happened
What were the root causes of the accident/incident? Consider the following factors:
People:
Equipment:
Environment:
Procedures:
Organisation:

What can be done to prevent it happening again?

What needs to be done now?	Who should do it?	By when?
Incident/Accident investigated by:	Date:	Signature:

<i>Head of Dept. / Line Manager</i>	<i>Department</i>	Date:	Signature: