INCIDENT REPORT FORM

Worksafe Notification Ref No:





DETAILS OF PERSON COMPLETING THIS FORM

Sumane Sumane Sumane Work Ph No			Contractor		Super	rvisor/Host Employe	r [MelRec/QueRec Employee	
Contractor Supervisor/Host Employer MelRec/QueRec Employee Given Name: Date of Birth Date of Birth	Give	n Name		Surname	Surname:				
Given Name: Surrame: Date of Birth	Role Title: Organ				nisation:			Mobile Ph No	
Given Name: Surname: Date of Birth Home Address Home Ph No Host Employer Name: Position: Supervisor's Name Site Address: Work Ph No Work Ph No	DETAIL	S OF PERSON <mark>I</mark>	NVOLVED IN	INCIDENT					
Home Address			Contractor		Supervi	sor/Host Employer		MelRec/QueRec Employee	
Host Employer Name: Position: Supervisor's Name	Give	Given Name:			Surname:		Date of Birth		
Site Address: Work Ph No	Hom	e Address					Hom	ne Ph No	
Type of Report	Host Employer Name:				Position:		Supervisor's Name		
Type of Report	Site Address:						Work Ph No		
Injury	NCIDE	NT DETAILS							
Near miss	Туре	of Report	Place / lo	cation of Ir	ncident				
Type of Incident Slip, trip, fall Manual handling Struck by object Motor vehicle Chemical Pre-injury Duties Incident or Near Miss Summary - how did it happen? Briefly describe injuries if any REATMENT DETAILS Treatment First Aid Doctor's Visit Hospital Visit FIRST AND SIID, trip, fall Who was the incident/near miss reported to? Witness/es Name Witness Contact Ph No Certificate of Capacity Issued Yes / No /		Injury							
Slip, trip, fall Who was the incident/near miss reported to? Manual handling Struck by object Motor vehicle Have you returned to work? Date you returned to work Certificate of Capacity Issued Y / N Yes / No Yes / No Electrical What duties can you now perform? Other Pre-injury Duties Suitable Duties Unfit For Any Duties Incident or Near Miss Summary - how did it happen? Briefly describe injuries if any Treatment Treated by Treatment date First Aid Doctor's Visit Address Ph No Hospital Visit Ph No ECLARATION Details to medical practitioners, investigators and other experts, for the purpose of assessing and managing any orkers compensation claim relating to the incident referred to on this form.				ncident	Time of Incident			Did you cease work? Date?	
Manual handling Witness/es Name Witness Contact Ph No	Туре	of Incident				am□ / pm [Y 🗌 / N 🗍	
Struck by object Motor vehicle		Slip, trip, fall	Who was	Who was the incident/near miss reported to?					
Struck by object		Manual handlin	g Witness/	Witness/es Name Witness Contact Ph No					
Motor vehicle			_						
Chemical				Have you returned to work? Date you returned to				Certificate of Capacity Issued	
Other		Chemical	-						
Briefly describe injuries if any REATMENT DETAILS Treatment Treated by Treatment date First Aid Doctor's Visit Address Ph No Hospital Visit DECLARATION Certify that the information I have provided is correct. I consent to MelRec/QueRec collecting and using my personal information, ad/or disclosing these details to medical practitioners, investigators and other experts, for the purpose of assessing and managing any orkers compensation claim relating to the incident referred to on this form.		Electrical	What dut						
Briefly describe injuries if any REATMENT DETAILS Treatment Treated by Treatment date First Aid Doctor's Visit Address Ph No Hospital Visit Address Ph No BECLARATION Certify that the information I have provided is correct. I consent to MelRec/QueRec collecting and using my personal information, and/or disclosing these details to medical practitioners, investigators and other experts, for the purpose of assessing and managing any orkers compensation claim relating to the incident referred to on this form.		·							
Treatment Treated by Treatment date First Aid				how did it	happen?				
First Aid Doctor's Visit Hospital Visit DecLARATION Certify that the information I have provided is correct. I consent to MelRec/QueRec collecting and using my personal information, nd/or disclosing these details to medical practitioners, investigators and other experts, for the purpose of assessing and managing any orkers compensation claim relating to the incident referred to on this form.	REAT	MENT DETAILS							
Doctor's Visit Address Ph No Hospital Visit Address Ph No DECLARATION	Trea	tment Treated by					Treatment date		
Hospital Visit DECLARATION Certify that the information I have provided is correct. I consent to MelRec/QueRec collecting and using my personal information, and/or disclosing these details to medical practitioners, investigators and other experts, for the purpose of assessing and managing any orkers compensation claim relating to the incident referred to on this form.		First Aid							
DECLARATION certify that the information I have provided is correct. I consent to MelRec/QueRec collecting and using my personal information, and/or disclosing these details to medical practitioners, investigators and other experts, for the purpose of assessing and managing any torkers compensation claim relating to the incident referred to on this form.			Address	Address			Ph No		
certify that the information I have provided is correct. I consent to MelRec/QueRec collecting and using my personal information, nd/or disclosing these details to medical practitioners, investigators and other experts, for the purpose of assessing and managing any orkers compensation claim relating to the incident referred to on this form.		Hospital Visit							
Signature Name (printed) Date Signed	certify t	hat the information lisclosing these deta	ils to medical pr	actitioners, i	nvestigators	and other experts, for the			
MAINE DIRECTOR CONTRACTOR CONTRAC	Sign	atura			Nom	a (printed)		Data Signed	