## INJURY, ILLNESS AND INCIDENT FORM

This form is used by **employees** and other **visitors** to the CSO or school if they are involved in an incident resulting in an injury or illness. **Do NOT use this form for student incidents.** Please refer to the Recover at Work Procedure when completing this form. This form is to be completed in full, electronically or as a hard copy, and forwarded by email or fax to the Return to Work Coordinator, Employee Services on the same day as the incident.

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| **1. DETAILS OF PERSON INVOLVED** | | | | | | | | | | | | | | | | |
| Surname: | | | | | | | | Given names: | | | | | | | | |
| Date of birth: | | | | | | | | Age: | | | | | | | | |
| Gender: Male  Female | | | | | | | | Phone number: | | | | | | | | |
| Home address: | | | | | | | | | | | | | | | Postcode: | |
| School/workplace: | | | | | | | | Occupation: | | | | | | | | |
| Employee | | Volunteer | | | | Contractor | | | | | Visitor | | | | Religious Order | |
| **2. DETAILS OF INCIDENT** | | | | | | | | | | | | | | | | |
| **Please indicate where the injury or illness occurred** | | | | | | | | | | | | | | | | |
| At work or during a school-related activity | | | | | | | | | | | |  | | | | |
| During an authorised break | | | | | | | | | | | |  | | | | |
| Vehicle accident while working/during school-related activity | | | | | | | | | | | |  | | | | |
| **When did the incident occur (or approximate date of first exposure or onset of illness)?** | | | | Date: | | | | | | | | | Time: | | | |
| **To whom was the injury reported?** | | | | Name: | | | | | | | | | | | | |
| **What was the nature of the injury or illness?** | | | | (e.g. suspected fracture, sprain, burn, deafness) | | | | | | | | | | | | |
| **What part of the body was affected?** | | | | (e.g. left hand, lower back, right eye) | | | | | | | | | | | | |
| **Where did the injury or illness occur?** | | | | (e.g. classroom, science lab, on excursion – specific location) | | | | | | | | | | | | |
| **Describe how the injury or illness occurred (What was being done at the time and how the injury/illness was sustained)** | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **3. WITNESS DETAILS** | | | | | | | | | | | | | | | | |
| Were there any witnesses? | | | | | | | Yes  No | | | | | | | | | |
| Name of witness: | | | | | | | | | | | | | | | | |
| **4. TREATMENT DETAILS** | | | | | | | | | | | | | | | | |
| No | First Aid | | | | Doctor | | | | | Hospital | | | | | | Other |
| Treatment details (include the first aider’s name, any first aid action, the name of the hospital admitted to, etc.): | | | | | | | | | | | | | | | | |
| **5. DOCTOR DETAILS (IF REQUIRED)** | | | | | | | | | | | | | | | | |
| Treating doctor’s name: | | | | | | | | | Initial consultation date: | | | | | | | |
| Doctor contact details: | | | | | | | | | | | | | | | | |
| Was a medical certificate issued?  Yes  No | | | | | | | | Medical diagnosis: | | | | | | | | |
| Has the same or similar injury been suffered previously?  Yes  No | | | | | | | | Details: | | | | | | | | |
| If required, I authorise the CSO and Catholic Church Insurance to obtain medical and related information with respect to this notification | | | | | | | | Signature of injured person: | | | | | | | | |
| Date: | | | | | | | | |
| **6. OUTCOME** | | | | | | | | | | | | | | | | |
| Did the person cease work or study? Yes  No | | | | | | | | Date: | | | | | | Time: | | |
| Is any time off work required?  Yes  No | | | | | | | | Anticipated/expected return to work date: | | | | | | | | |
| **7. DETAILS OF PERSON COMPLETING FORM** | | | | | | | | | | | | | | | | |
| Self | | | Other | | | | | | | |  | | | | | |
| Full name: | | | | | | | | | | | | | | | | |
| Position: | | | | | | | | | | | | | | | | |
| Signature of person completing form: | | | | | | | | Date injury notified to Principal/Head of Service: | | | | | | | | |
| Signature of Principal/Head of Service (required in all cases): | | | | | | | | Date: | | | | | | | | |