2018
NDIS

EMPLOYEE INCIDENT FORM

National Premier Disability Services

ADMIN | 0416 855 097

Document Control

Document Number:	0045	Version:	1
Created Date:	1 Nov 2018	Created By:	Outflow Australia
Modified Date:		Modified By:	
Approved Date:		Approved By:	

(please complete all the details below and attach all relevant documentation)

NAME:

……

JOB TITLE:

……

POSTAL ADDRESS:

……

PHONE NUMBERS: HOME: …… MOBILE:……..

EMAIL ADDRESS: ……

DETAILS OF INCIDENT: (where applicable please tick appropriate box)

WHEN DID THE INCIDENT OCCUR?

DAY:……..DATE: ……TIME: …… AM/PM

WHERE DID THE INCIDENT OCCUR?

……

……

WHAT WERE THE CIRCUMSTANCES?

……

……

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……

WERE THERE ANY WITNESSES? ☐ ☐

NAME OF WITNESS:

……

TELEPHONE NUMBER: …… JOB TITLE:…….

WAS FIRST AID TREATMENT PROVIDED? YES ☐ NO ☐

(if yes please give details)

……

……

……

WAS MEDICAL TREATMENT PROVIDED? YES ☐ NO ☐

(if yes please give details)

……

……

……

DID YOU REQUIRE AN AMBULANCE? YES ☐ NO ☐

DID YOU GO TO HOSPITAL? YES ☐ NO ☐

DID YOU VISIT YOUR GP? (please write date and time)

……

……

RESULT OF GP VISIT:

……

……

……

……

……

ACTION TAKEN:

……

……

……

……

……

REVIEW DATE: ……

IS FURTHER ACTION TO BE TAKEN? YES ☐ NO ☐

ADDED TO CQI ☐ **OHS MEETING AGENDA** ☐ **INSURANCE CLAIM** ☐

EMPLOYEE SIGNATURE: ……**DATE:** ……

OFFICE USE ONLY

WITNESSED **COPY TO EMPLOYEE** **SCANNED TO FILE**

DATE ……. **DATE ……..DATE …….**