



## INJURY REPORT FORM

*Enter all information onto IRMS within 12 hours – refer notes page 4*

PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS.

### Worksite

|                             |                                              |
|-----------------------------|----------------------------------------------|
| 1. Worksite:                | Location No:                                 |
| Name of Site Manager:       | Telephone:                                   |
| Date of Injury:     /     / | Time of Injury (24hr clock) :     :     Hour |

### Affected Person

|                                                                                                                                      |                                                                    |
|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| 2. Surname                                                                                                                           | First Name                                                         |
| Date of Birth:     /     /                                                                                                           | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Is the affected person a DECD worker? <input type="checkbox"/> Yes (Go to Section 2A) <input type="checkbox"/> No (Go to Section 2B) |                                                                    |

### 2A DECD Worker

|                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|
| ID NO:                                                                                                                                                                                                                                                                                                                                                                                                            | Employment: <input type="checkbox"/> Permanent <input type="checkbox"/> Casual <input type="checkbox"/> Contract |
|                                                                                                                                                                                                                                                                                                                                                                                                                   | Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time                                    |
| Work Role: <input type="checkbox"/> Teacher <input type="checkbox"/> SSO <input type="checkbox"/> Site Manager <input type="checkbox"/> Line Manager <small>supervisory role other than site manager</small><br><input type="checkbox"/> ECW <input type="checkbox"/> AEW <input type="checkbox"/> GSE <input type="checkbox"/> PS Act Worker <input type="checkbox"/> Director <small>Director/Corporate</small> |                                                                                                                  |
| Was time lost from work? <input type="checkbox"/> No <input type="checkbox"/> Yes <small>(More than half day)</small> Date ceased work:     /     / Time:     :     Hours <small>(24 hour clock)</small>                                                                                                                                                                                                          |                                                                                                                  |
| Will a workers compensation claim be lodged? <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Yes<br><small>If Yes, forward WorkCover SA claim form and Prescribed Medical Certificate as soon as possible to:<br/>Health &amp; Safety Services, Courier R21/7 Injury Management Helpline Tel: 8226 7555 available for advice.</small>                                        |                                                                                                                  |

Name of Person completing form:

### 2B Non-DECD person

|                                                                                                                                                                                                                                |            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| Status: <input type="checkbox"/> Student <input type="checkbox"/> Visitor <input type="checkbox"/> Contractor <input type="checkbox"/> Voluntary Worker <input type="checkbox"/> Other <small>e.g. Paid by Site, Govt.</small> |            |
| Home Address:<br><br>Post code:                                                                                                                                                                                                | Telephone: |
| Name of person in charge:<br><small>i.e. DECD person on duty at time.</small>                                                                                                                                                  | Work Role: |

### 3. Details and Initial Assessment of Injury if insufficient space is provided on this form, please attach additional sheet

|                                                 |
|-------------------------------------------------|
| What was the affected person doing at the time? |
| What happened?                                  |

### 4. Description of prior events and contributing factors

|                                                                     |
|---------------------------------------------------------------------|
| Describe any prior act or event that may have led up to the injury. |
|---------------------------------------------------------------------|

### 5. Witnesses if applicable

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**Yicheng Fang**



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neeson noma dumezweni lilly aspell jack champion embeth davidtz and matthew modine it is the third remake of the 2015  
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