



## 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: Male Female |
| Is the affected person a DECD worker? <input type="checkbox"/> Yes (Go to Section 2a) <input checked="" type="checkbox"/> No (Go to Section 2b) |                  |

### 2a DECD Worker

|                                               |                                                         |                                                                                                                                                                                                                  |                                    |                                                                                                         |
|-----------------------------------------------|---------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---------------------------------------------------------------------------------------------------------|
| ID NO:                                        | Employment:                                             | Permanent                                                                                                                                                                                                        | Casual                             | Contract                                                                                                |
|                                               | Status:                                                 | Full-time                                                                                                                                                                                                        | <input type="checkbox"/> Part-time |                                                                                                         |
| Work Role:                                    | Teacher<br>ECW                                          | SSO<br>AEW                                                                                                                                                                                                       | Site Manager<br>GSE                | Line Manager: supervisory role other than site manager<br>PS Act Worker<br>Director: District/Corporate |
| Was time lost from work?                      | No<br><input type="checkbox"/> Yes (More than half day) | Date ceased work: / /                                                                                                                                                                                            | Time: : .Hours                     | (24hr clock)                                                                                            |
| Will a workers' compensation claim be lodged? | No<br><input type="checkbox"/> Yes                      | If Yes, forward WorkCover SA claim form and Prescribed Medical Certificate as soon as possible to:<br>Health & Safety Services, Counter R21/7<br>Injury Management Helpline Tel: 8225 7555 available for advice. |                                    |                                                                                                         |

Name of Person completing form:

|                                                                 |         |         |                       |                                                                           |
|-----------------------------------------------------------------|---------|---------|-----------------------|---------------------------------------------------------------------------|
| 2b Non-DECD person                                              |         |         |                       |                                                                           |
| Status:                                                         | Student | Visitor | Contractor            | Voluntary Worker <input type="checkbox"/> Other (e.g. Paid by Site, Govt) |
| Home Address:                                                   |         |         | Telephone:            |                                                                           |
| Name of person in charge:<br>(i.e. DECD person on-duty at time) |         |         | Post code: 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

# Injury Report Guide Customer Service

**United States. Bureau of Animal  
Industry**

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Court of the State of Illinois Illinois. Supreme Court,1899      **Lawyers' Reports Annotated** ,1890      **Reports of Cases Argued and Determined in the Supreme Court of Errors of the State of Connecticut** Connecticut. Supreme Court,Connecticut. Supreme Court of Errors,1896      Reports of Cases Determined in the Supreme Court of the State of California California. Supreme Court,1899      American Law Reports ,1980      **Reports of Cases Heard and Determined in the Supreme Court of the State of New York** Marcus Tullius Hun,New York (State). Supreme Court,1894      *Service and Regulatory Announcements* United States. Bureau of Animal Industry,1914

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web 1 i am a new caregiver a caregiver for some time caring for my care recipient with advanced medical conditions 2 my care recipient has dementia stroke 3 my care recipient s name 4 my care recipient is in ttsh ward ttsh renci ward ttsh emergency department not admitted to wards ttsh rehab ward not applicable

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