

Accident/Incident Notification

Worker or Workplace Participant to complete this form. If the accident or incident is to be reported to Worksafe NZ – this must be done within 48 hours.

Reporter Details

Name: _____

Role _____

Accident/Incident Details

Place of Accident/Incident: _____

Description: _____

Date Occurred: _____ Time: _____ Date Reported: _____ Time: _____

Work ceased (Y/N): _____ Date: _____ First Aid Required? Y/N _____

ACC Contacted(Y/N) _____ Medical Treatment required? Yes No

Type of Incident	Nature of Injury	Part of the body injured
<input type="checkbox"/> Flying Object	<input type="checkbox"/> Sprain	<input type="checkbox"/> Neck
<input type="checkbox"/> Struck by _____	<input type="checkbox"/> Fracture	<input type="checkbox"/> Head
<input type="checkbox"/> Caught in _____	<input type="checkbox"/> Multiple contusion	<input type="checkbox"/> Eyes
<input type="checkbox"/> Manual Handling	<input type="checkbox"/> Laceration	<input type="checkbox"/> Trunk
<input type="checkbox"/> Poison	<input type="checkbox"/> Concussion	<input type="checkbox"/> Arm
<input type="checkbox"/> Temperature	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Leg
<input type="checkbox"/> Electricity	<input type="checkbox"/> Burn	<input type="checkbox"/> Multiple
<input type="checkbox"/> Fall	<input type="checkbox"/> Superficial	<input type="checkbox"/> General
<input type="checkbox"/> Other _____	<input type="checkbox"/> Amputation	<input type="checkbox"/> Unspecified
	<input type="checkbox"/> Other: _____	

Nature and Extent of Injury:

Actions Taken:



**MALE SURVIVORS
TARANAKI**
NGĀ TĀNE MŌREHU O TARANAKI

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