|  |
| --- |
| **REGISTER OF INJURY**  |
| **Type Employer Name Here** |

|  |
| --- |
|  Employee Particulars |
|  | Name:       | Employee No.:       |  |
|  | Address :       | Supervisor::       |  |
|  | Date of Birth:       | Occupation:       |  |
|  | Sex:       |  |  |
|  Particulars of Incident |
|  | Date of Incident:       | Time of incident:      am[ ]  pm[ ]  | Date injury notified:       |  |
|  | Location at time of incident:       |  |
|  | Description of incident:       |  |
|  |       |  |
|  |       |  |
|  | Were there any witnesses to the incident: | Yes [ ]  | No [ ]  |  |
|  | Name:       | Phone:       |  |
|  | Name:       | Phone:       |  |
|  | Did you sustain an injury as a result of the incident: | Yes [ ]  | No [ ]  |  |
|  | Particulars of injury |  |
|  | Nature of injury:       |  |
|  | Part/s of body injured:       |  |
|  | Did you require treatment/first aid: | Yes [ ]  | No [ ]  |  |
|  | Treatment given by:       |  |
|  | Details of treatment:       |  |
|  |       |  |
|  | Did the worker return to work after the treatment:  | Yes [ ]  | No [ ]  **If no, initiate RTW procedures.** |  |
|  |  | Normal Duties [ ]  | Alternative Duties [ ]  |  |
|  |  |  |
|  | Name of person making entry:       |  |
|  | Relationship to injured person:       |  |
|  | Signature:  | Date:      |  |
|  | Employer Acknowledgment |  |
|  | Name:       | Signature |  |
|  | Position:        | Date:      |  |
|  | Victorian WorkCover Authority Notification Required |  Yes [ ]  |  No [ ]  |  |
|  | To whom       | Date:      | Time:      |  |
|  | ***Please note that this document may require a Privacy Statement. Please discuss with your company’s legal representative.*** |  |

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