|  |
| --- |
| **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.*** | | | | | | | | | |  |

**Allianz Australia Workers' Compensation (Victoria) Limited** ACN 059 835 791 Authorised Agent of the Victorian WorkCover Authority Principal Business Address: PO Box 80, Melbourne, VIC, 3001