



Tauawhi Charitable Trust

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:



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Actions Taken: