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Workplace Injury Reporting Form

(To be completed by injured worker)

Family name

Given name

☐ Male ☐ Female

Home Address

Post Code

Home Phone

Mobile Phone

Date of Birth

Email Address

Job Title

Main Duties

Workers experience in task being carried out when injury occurred
Years months

Relating to an Injury

When did it happen (d/m/y) / /

time am/pm

Did you stop work or normal duties?
YES/NO

When did you stop work or normal duties?
(d/m/y) / /

time am/pm

Company working for at time of accident.

To whom was the accident reported?

Position within company.

Do you have a Workcover Medical Certificate?
YES/NO

Nature of injury (as shown on NSW Workcover Medical Certificate)

Was the effected part of the body normal before the accident YES/NO

How exactly was the injury caused?

Where did it happen (give exact details eg: store department, job site address)?

Are you expected to return to work?
YES/NO

What is the expected return date?
(d/m/y) / /

Are you likely to resume normal duties on your return to work?
YES/NO

If no, list suitable duties as indicated on NSW Workcover Medical Certificate.

Were there any witnesses to the injury/illness?
YES/NO

Name of Witness
(daytime phone number or address)

SIGNED

NAME DATE

I declare that the information that I have provided in this form is correct

DATE REPORTED TO LABOUR OPTIONS