MAG
Supporting Your Future

DETAILS OF PERSON COMPLETING THIS FORM **INCIDENT REPORT FORM**

Person Involved in Incident ☐ **MAG Apprentice** ☐ **Supervisor/Host Employer** ☐ **Contractor/Visitor** ☐

Surname	Given Name(s)	Work Ph No:
Role Title:	Organisation:	Mobile Ph No

DETAILS OF PERSON INVOLVED IN INCIDENT

☐ **Apprentice** ☐ **MAG Employee** ☐ **Visitor**

Surname	Given Name(s)	Date of Birth	Sex
Home Address		Home Ph No	
Employer or Host Employer Name:	Position Title	Supervisor's Name	
Site Address:		Work Ph No	

INCIDENT DETAILS

Type of Report ☐ Injury ☐ Near miss	Place / location of Incident		
	Date of Incident	Time of Incident am☐ / pm ☐	Did you cease work? Date? Y ☐ / N ☐
Type of Incident ☐ Slip, trip, fall ☐ Manual handling ☐ Struck by object ☐ Motor vehicle ☐ Chemical ☐ Electrical ☐ Other	Who was the incident/near miss reported to? Y ☐ / N ☐		
	Witness/es Name		Witness Contact Ph No
	Have you returned to work? Y ☐ / N ☐	Date you returned to work	Time you returned to work am☐ / pm ☐
	What duties can you now perform? ☐ Pre-injury Duties ☐ Suitable Duties ☐ Totally Unfit For Any Duties		
Incident or Near Miss Summary - how did it happen?			
Briefly describe injuries if any			

TREATMENT DETAILS

Treatment ☐ First Aid ☐ Doctor's Visit ☐ Hospital Visit	Treated by	Treatment date
	Address	Ph No

DECLARATION

I certify that the information I have provided is correct. I consent to MAG collecting and using my personal information, and/or disclosing these details to medical practitioners, investigators and other experts, for the purpose of assessing and managing any workers compensation claim relating to the incident referred to on this form.

Signature _____ Name (printed) _____ Date Signed _____

Once completed, please email immediately to katrina@magroup.org