INJURY REPORT FORM

USE THIS FORM TO REPORT A WORKPLACE INJURY

Given name		Date of injury	
Surname		Time of injury	
Residential address		When did the injury occur?	☐ During work hours ☐ Journey to/ from work ☐ During work break ☐ Other
Postcode		Address where injury took place	
Suburb			
State		Provide details of the injury e.g. what happened?	
Contact numbers	Home - Work - Mobile -		
Date of birth		Provide details of injury sustained e.g. which parts of your body are affected?	
Employee Number			
Gender	☐ Male ☐ Female		
Position held			
Department/ Line of Business		Do you have any pre-existing injuries/ conditions?	
Work address			
Supervisor's name		Action taken	☐ I received First Aid treatment ☐ I went to see a doctor ☐ No action was taken ☐ Other ……..
Supervisor's contact details			

Employment status	☐ I am a contractor/temporary working for a Hudson client ☐ I am a part time, full time or casual Hudson employee ☐ Other ……	Name of Doctor or Hospital if you have sought treatment	
Name of your Hudson Consultant (only applicable if you are a contractor/ temporary working for a Hudson client)		Please provide details for any witnesses to the injury	

Form completed by:..... Date: ……..

NEXT STEPS

Forward this completed form and any other relevant documentation to the Safety Advisor AUST/NZ:

Name: Sylvia Kaczmarek

Email: sylvia.kaczmarek@hudson.com

Fax: 61 2 9233 8266

Post: Attn: Sylvia Kaczmarek
Safety Advisor AUST/NZ
Legal & Risk Team
GPO Box 3995
Sydney NSW 2001

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Received (date)		Received by	
Cost Centre Code			