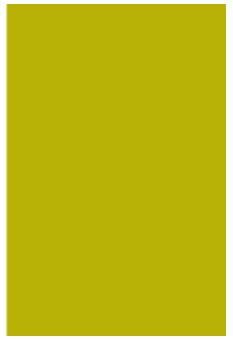


INJURY REPORT FORM
USE THIS FORM TO REPORT A WORKPLACE INJURY

Given name		Date of injury	
Surname		Time of injury	
Residential address		When did the injury occur?	<input type="checkbox"/> During work hours <input type="checkbox"/> Journey to/ from work <input type="checkbox"/> During work break <input type="checkbox"/> 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	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Position held			
Department/ Line of Business		Do you have any pre-existing injuries/ conditions?	
Work address			
Supervisor's name		Action taken	<input type="checkbox"/> I received First Aid treatment <input type="checkbox"/> I went to see a doctor <input type="checkbox"/> No action was taken <input type="checkbox"/> Other
Supervisor's contact details			



Employment status	<input type="checkbox"/> I am a contractor/temporary working for a Hudson client	Name of Doctor or Hospital if you have sought treatment	
	<input type="checkbox"/> I am a part time, full time or casual Hudson employee		
	<input type="checkbox"/> Other		
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

OFFICE USE ONLY

Received (date)		Received by	
Cost Centre Code			