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? Is yes please provide details.	
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 / engagement status	☐ I am a contractor/temp working for at a Hudson client worksite ☐ I am a direct Hudson employee working at Hudson offices ☐ Other ……	Name of doctor or hospital if you have sought treatment	
Name of your Hudson Consultant (only applicable if you are a contractor/ temp working at a Hudson client worksite)		Please provide details for any witnesses to the injury	

What preventative measures have been taken or could be taken to prevent reoccurrence (if any)?
Please provide any other relevant details

Form completed by:

Date:

Next Steps

Forward this completed form and any other relevant documentation to Safety@hudson.com