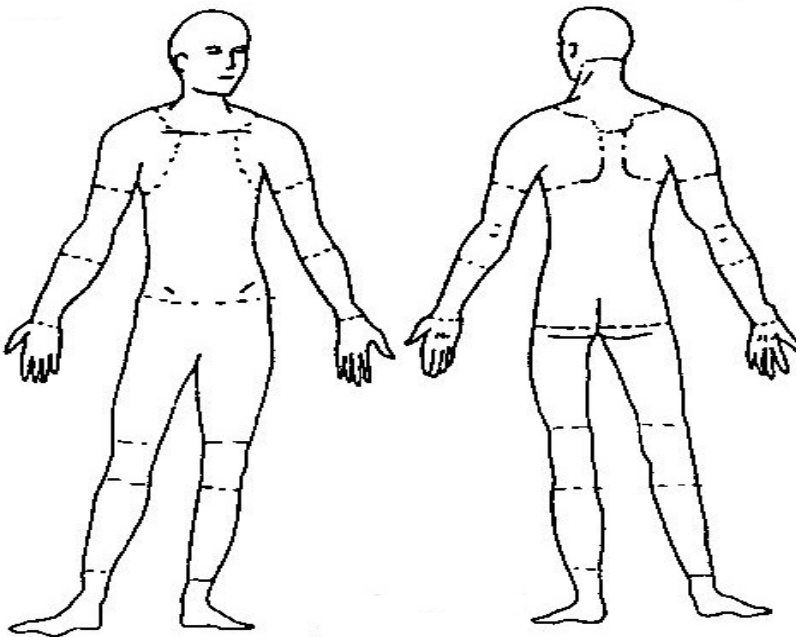


4. Details of Injured Parties.						
Name of Injured Person/s:						
Company Employed By:						
Gender:						
Date of Birth:						
Employment Status:	Full Time:		Part Time:		Casual:	
Contact Details:						
Address:						
Point of contact name and telephone:						
Reported As:	First Aid Only		Lost Time Injury		Fatality	
FIPASS Induction Undertaken:						
Was appropriate PPE Being Worn:						
Was Medical Assistance called:						
Part of body affected: (shade all that apply)						



Nature of injury:
<input type="checkbox"/> Abrasion, scrapes
<input type="checkbox"/> Amputation
<input type="checkbox"/> Broken bone
<input type="checkbox"/> Bruise
<input type="checkbox"/> Burn (heat)
<input type="checkbox"/> Burn (chemical)
<input type="checkbox"/> Concussion (to the head)
<input type="checkbox"/> Crushing Injury
<input type="checkbox"/> Cut, laceration, puncture
<input type="checkbox"/> Hernia
<input type="checkbox"/> Illness
<input type="checkbox"/> Sprain, strain
<input type="checkbox"/> Damage to a body system:
<input type="checkbox"/> Other _____