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EMPLOYEE INCIDENT/INJURY REPORT

All incident/injuries must be reported to the immediate team leader/manager/supervisor and Global Disability within 24 hours. This form is to be used to record incidents involving Global Disability Employee only.

PART 1: EMPLOYEE DETAILS

Name: _____ **Date of Birth:** _____

Address: _____

Mobile: _____

PART 2: DETAILS OF INCIDENT

Date of incident/Injury: _____ **Time of Incident:** _____ : _____

Description of Injury (Shoulder pain/neck pain/bruising etc): _____

Where did the incident take place (eg. name of group home): _____

Description of incident (including injuries sustained and Immediate action taken):

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PART 3: IMMEDIATE MEDICAL ACTION

Was a medical officer seen? YES / NO

If YES, state investigations and treatment ordered:

_____

_____

_____

(Please provide medical transcript/certificate)

Part 4: WITNESS

Name: _____ **Contact Number:** _____

PART 5: REPORTING THE INCIDENT

Was the incident/injury reported? YES / NO If YES note date and time reported: _____ & _____ **:** _____

Please note down contact Name of whom you reported the incident/injury to:

Global Contact Name: _____ **Supervisor Name:** _____

SIGNED: _____ **DATE:** _____

PRINT NAME: