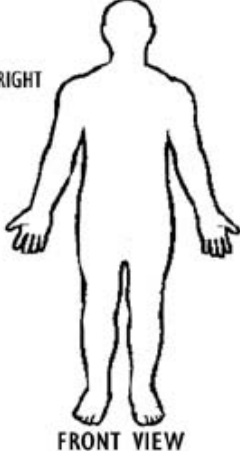
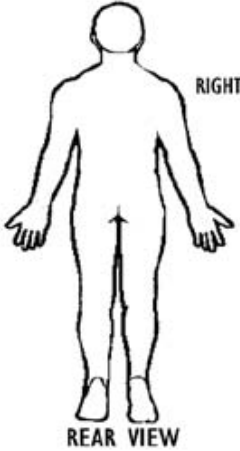


BRAVO DISABILITY SUPPORT NETWORK INC.

ACCIDENT AND INJURY REPORT

Details of incident (eg to a worker or visitor) and treatment			
Date of incident			
Time of incident	<input type="checkbox"/> am <input type="checkbox"/> pm		
Nature of incident	<input type="checkbox"/> Near miss <input type="checkbox"/> First Aid <input type="checkbox"/> Medical treatment/doctor		
Name of injured person			
Address			
Occupation			
Date of birth			
Telephone			
Employer			
Activity in which the person was engaged at the time of injury			
Exact site location where injury occurred			
Nature of injury – eg fracture, burn, sprain, foreign body in eye			
Body location of injury (indicate location of injury on the diagram)	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <p>RIGHT</p>  <p>FRONT VIEW</p> </div> <div style="text-align: center;"> <p>LEFT</p>  <p>REAR VIEW</p> </div> </div>		
Treatment given on site		Name of treating person	
Referral for further treatment? Yes <input type="checkbox"/> No <input type="checkbox"/>	Name of doctor or hospital	WorkCover medical certificate received? Yes <input type="checkbox"/> No <input type="checkbox"/>	Attach copies
Injury management required? Yes <input type="checkbox"/> No <input type="checkbox"/>	Notify return to work Manager	Name of return to work Manager	
Witness to incident (each witness may need to provide an account of what happened)			
Witness name		Witness contact	
Witness name		Witness contact	

