



MIRVISH PRODUCTIONS

Brief Description of Incident, Contributing Factors and Additional Information (for example: clothing, weather conditions age/health conditions, etc.)

Area of Injury (Body Part)																							
<input type="checkbox"/>	Head	<input type="checkbox"/>	Teeth	<input type="checkbox"/>	Upper Back	Left	Right	<input type="checkbox"/>	Wrist	<input type="checkbox"/>	Right	Left	Right	<input type="checkbox"/>	Hip	<input type="checkbox"/>	Right	Left	Right	<input type="checkbox"/>	Ankle	<input type="checkbox"/>	Right
<input type="checkbox"/>	Face	<input type="checkbox"/>	Neck	<input type="checkbox"/>	Lower Back	<input type="checkbox"/>	Shoulder	<input type="checkbox"/>	Hand	<input type="checkbox"/>	Left	<input type="checkbox"/>	Left	<input type="checkbox"/>	Thigh	<input type="checkbox"/>	Right	<input type="checkbox"/>	Foot	<input type="checkbox"/>	Right	<input type="checkbox"/>	Right
<input type="checkbox"/>	Eye(s)	<input type="checkbox"/>	Chest	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	Arm	<input type="checkbox"/>	Finger(s)	<input type="checkbox"/>	Right	<input type="checkbox"/>	Right	<input type="checkbox"/>	Knee	<input type="checkbox"/>	Right						
<input type="checkbox"/>	Ear(s)	<input type="checkbox"/>	Pelvis	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	Elbow	<input type="checkbox"/>	Toe(s)	<input type="checkbox"/>	Right	<input type="checkbox"/>	Right	<input type="checkbox"/>	Calf	<input type="checkbox"/>	Right						
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	Forearm	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	

Is there anyone else who may have witnessed or were directly involved with the incident? Yes No

If Yes:

1. Name	Job Title	Phone Number
2. Name	Job Title	Phone Number

3. Health Care (If known)

Did the worker receive health care for this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	When did the employer learn that the worker received health care? dd mm yyyy
If Yes, when dd mm yyyy	dd mm yyyy
Was First Aid Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Who Provided First Aid?	
Name	Position
	Are they Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No
What was done / advice given:	



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Was an Ambulance was called?		
Yes	If yes, what time did it arrive:	Time <input type="checkbox"/> AM
No		<input type="checkbox"/> PM
Where was the worker treated for this Injury		
<input type="checkbox"/> On-Site <input type="checkbox"/> Ambulance <input type="checkbox"/> Emergency Room <input type="checkbox"/> Admitted to Hospital <input type="checkbox"/> Health Professional Office <input type="checkbox"/> Clinic		
<input type="checkbox"/> Other _____		
Facility Information where the worker was treated (If known)		
Name	Address	Phone Number

4. Lost Time (If known)

1. Please choose one of the following indicators. After the day of accident/awareness of illness, this worker:		
<input type="checkbox"/> Returned to their regular job without time off following injury/incident.		
<input type="checkbox"/> Returned to modified work without time off following injury/incident.		
<input type="checkbox"/> Worker took time off following injury/incident.		
Provide date worker first took time off		Date worker returned to work (if known)
dd	mm	yyyy
dd	mm	yyyy
		<input type="checkbox"/> Regular Work
		<input type="checkbox"/> Modified Work
This Time off/Modified Work information was confirmed by:		
Name	Job Title	Phone Number
Manager responsible for arranging worker's return to work?		
Name	Job Title	Phone Number

Report Completed By:

Name	Job Title
Email	Date (dd/mm/yyyy)