

## REGISTER OF INJURIES

Name of injured person:	_____	Gender: Male <input type="checkbox"/>	Female <input type="checkbox"/>
Residential Address:	_____ _____		
Contact Phone Number:	_____		
Position (e.g. Volunteer):	_____		
Date and time of injury:	Date: / /	Time:	am/pm

Nature of injury, including body parts affected:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Cause of injury:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of witness/es:

\_\_\_\_\_

Contact Phone Number:

\_\_\_\_\_

Treatment administered:

\_\_\_\_\_  
\_\_\_\_\_

Name of First Aid attendant:

\_\_\_\_\_

Was the person referred for further treatment? Yes  No

Was an **Accident Incident Report** form completed? Yes  No

### PROJECT MANAGER ACKNOWLEDGEMENT

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: / /