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## HEALTH & SAFETY POLICY

### INCIDENT REPORT FORM

Date: \_\_\_\_\_ Location: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

Name of injured person: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Date of birth: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Who was injured person? (Circle one)      Participant      Spectator

Type of injury: \_\_\_\_\_

Details of incident & names of any witnesses: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Was any medical attention desired and/or required?    Yes \_\_\_\_    No \_\_\_\_

Name of physician/hospital: \_\_\_\_\_

Address: \_\_\_\_\_

Physician/hospital phone number: \_\_\_\_\_

\_\_\_\_\_  
Position & Signature of Reporting Party      Date

\_\_\_\_\_  
Signature of Injured Party      Date

**IMPORTANT NOTICE:** Please return this form to either the Designated Competition Health & Safety Officer or to Boccia NSW within 24 hours of incident. *Insurance claims need to be notified immediately*