Medical Treatment Register

Incident Details

Date of Incident*: _____

Employee Name*: _____

Employee ID: _____

Department / Work Area: _____

Description of Injury / Illness*: _____

_____

Body Part Affected: _____

Treatment Details

Date of Treatment*: _____

Type of Treatment: _____ > *Options: First Aid, Clinic Visit, Hospitalisation, Other*

Treatment Description*: _____

_____

Medical Practitioner / Provider: _____

☐ **Medication Administered**

Outcome & Follow-up

Outcome*: _____ > *Options: Returned to work same day, Restricted duties, Lost time injury, Hospitalisation, Fatality, Other*

Days Lost (if applicable): *(Fill only if applicable)*

_____

☐ **Workers Compensation Claim Lodged?**

Claim Number: *(Fill only if applicable)*

_____

Follow-up Actions: _____

_____

Administration

Recorded By: _____

Record Date: _____

Signature: _____ *(Sign above)*