



Hospitality Group Training – Accident/Near Miss Report Form
Please complete and fax to (08) 8223 6170 within 24 hours of the accident or near miss.

Employee Comments :

Surname: _____ First/Other names: _____

Date of Birth: _____ Host Employer: _____

Date of accident/near miss: _____ Time: _____ am/pm

Type of injury: _____

Part of body injured: _____

Where did accident/near miss occur? _____

Was any equipment/tools involved? (specify) _____

Describe what happened: _____

Name of witness: _____

To whom was the accident/near miss reported: _____

Date reported: _____

Was medical treatment necessary by a doctor or hospital: Yes No

If yes, give details : _____

Treating Doctors Name: _____

Clinic Name: _____

Was time from work lost as a result of the injury? Yes No

If yes, state date(s) and time : _____

Signed _____ Date _____

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