Injury Classification Form

Name of employee	
ID Number	
Company	
Site	
Daye of injury/Incident	

DESCRIPTION OF INCIDENT/ACCIDENT

DIAGNOSIS

CLASSIFICATION	**REASON**
Incident	
FAC	
MTC	
LTI	
Fatality	

Further treatment					
Fit to return to work	**YES**		**NO**		
Not fit to return to work	**YES**		**NO**		
Review at Clinic	**YES**		**NO**		
Fitness Certificate	**YES**		**NO**		

Safety Officer	
Supervisor	
Other	

OMP: …… Date: ……..