CARE 24/7
HEALTHCARE

Care 24/7 Healthcare Limited
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Lone Worker - Duty of Care - AccidentIncidentNear Miss Report

Staff Member: _____ Date Employment Commenced: _____

DETAILS OF ACCIDENT / INCIDENT / NEAR MISS					DETAILS OF ANY INJURIES INCURRED	OUTCOME (e.g. time off work, hospital, etc)	Signature	Date
Date & Time	**Location**	**Details**		**Additional Details (witnesses etc)**				