

WORKPLACE INJURY AND DISEASE NOTIFICATION FORM

HEALTH AND SAFETY AT WORK (ADMINISTRATION) REGULATIONS 1996

About the employer or person in control

1. Registered name of the company _____
2. Trading name _____
3. Address of the registered office _____
4. Address of the workplace or where accident/occurrence took place _____
5. Main activity carried out at the workplace _____
6. Number of people employed at the workplace or site _____
7. Is there a OHS committee at the workplace or site Yes/No

About the injured or ill person

8. Surname _____ Given names _____
9. Sex (M or F) _____ 10. Date of birth _____
11. Is the injured or ill person an employee of the above company Yes/No
If no, go to section 16

BASIS OF EMPLOYMENT

12. Shift Arrangement
 1. _____ Fixed, standard or flexible hours
 2. _____ Rotating Shift
13. Number of hours
 1. _____ 8 hours or less
 2. _____ more than 8 hours (excluding overtime)

JOB DETAILS

14. Description of occupation or job title _____
Main task performed _____
15. Training provided

1. _____	Induction training	2. _____	Task specific training
3. _____	Both of the above	4. _____	Neither of the above

DETAILS OF THE INJURY OR DISEASE

(Refer to fifth and sixth Schedule)

16. Date injury occurred or disease reported Day Month Year
17. Time of injury or disease ____/____
18. Nature of injury or disease _____
19. Bodily location of injury or disease _____
20. Description of occurrence of injury or disease:
 - In which part of the workplace did the injury or disease exposure occur?
(e.g. machine, shop, freezer room) _____
 - What was the person doing at the time?
(e.g. driving a forklift truck, lifting bags of cement, typing) _____
 - What happened unexpectedly?
Include the name of any particular chemical, product, process or equipment involved (e.g. brakes failed on a forklift truck, slipped on wet floor, scaffolding collapsed, arm started hurting while typing on a word processor) _____
 - How was the injury sustained?
Include the time of any chemical, product, process or equipment involved. (e.g. hit head on cabin or fork lift truck, lacerated knee when landing on ground, arm hurt after a long period of typing) _____

LOST – TIME INJURY/DISEASE

Additional questions to be answered for cases which result in fatality or permanent disability, or where there is time lost from work of one or more day/shifts. These questions should be completed as soon as possible after the injury or disease is reported.

21. Employee’s preferred language _____
22. Type of employment: _____ Full-time _____ Part-time _____ Casual
23. Type of employee
 Wage/Salary earner _____ Trainee _____ Outworker _____ Apprentice
 _____ Pieceworker _____ Other
 Self-employed: _____ (including contractors and subcontractors)
 Unpaid worker _____ Work experience _____
24. Worker’s experience in task being carried out when injury or disease occurred _____ Years _____ Month

Details of person completing this form

Name: _____ Position: _____
 Signature: _____ Date: _____

OUTCOME OF INJURY/DISEASE

Questions 25-29 are about information that is not available at the time of the report of injury or disease. These questions should be answered as soon as the information becomes available. For some occurrences, questions will not be relevant.

25. Rehabilitation 1. _____ Required Day Month Year
 2. _____ Not required
26. Was the outcome injury or disease 1. _____
 2. _____
27. Preventative action proposed or taken

(Tick one or more boxes as appropriate)

	Proposed	Taken
Change to induction training	_____	_____
Change to ongoing training	_____	_____
Equipment / machinery modifications	_____	_____
Change to work procedures	_____	_____
Change to work environment	_____	_____
Equipment/machinery maintenance	_____	_____
Other job redesign	_____	_____
Other preventive action	_____	_____

28. Date of Resumption of work on: Day Month Year
 _____/_____/_____

29. Total number of working days lost _____

Employer to retain a copy of this Notification Form.