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.