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) ______________________ Date of birth ____________________________________________________
10. 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 forklift 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)

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  
   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)

<table>
<thead>
<tr>
<th>Proposed</th>
<th>Taken</th>
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<tbody>
<tr>
<td>Change to induction training</td>
<td>______</td>
</tr>
<tr>
<td>Change to ongoing training</td>
<td>______</td>
</tr>
<tr>
<td>Equipment / machinery modifications</td>
<td>______</td>
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<tr>
<td>Change to work procedures</td>
<td>______</td>
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<tr>
<td>Change to work environment</td>
<td>______</td>
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<tr>
<td>Equipment/machinery maintenance</td>
<td>______</td>
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<tr>
<td>Other job redesign</td>
<td>______</td>
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<tr>
<td>Other preventive action</td>
<td>______</td>
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</tbody>
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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.**