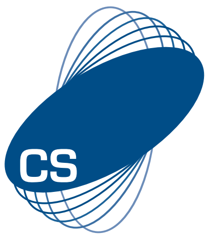

Coal Mines Insurance Pty Limited
ABN 70 000 011 727

Early Notification of Injury Form

Worker's name: ____________________

Worker's address: ____________________

Worker's phone number: ____________ Worker's date of birth: ____________

Name of employer: ____________________

Date employment commenced: ____________ Permanent Casual

Occupation of worker: ____________________

Shift/Roster Day Afternoon Night Weekend Rotating

Other please specify: ____________________

Date of injury: ____________________

Colliery or site where injury occurred: ____________________

Date injury reported to employer or supervisor: ____________________

Has the worker advised the employer that a claim is to be submitted? **YES** **NO**

If **YES**, date employer first became aware that a claim is to be submitted: ____________

Date CMI advised or first became aware that a claim was to be submitted: ____________

Part of body injured: ____________________

Type of injury: ____________________

Has the worker sought medical treatment? **YES** **NO**

If **YES**, name of doctor or hospital where treated: ____________________

Work Status

Off work At work suitable duties At work pre-injury duties

Comments:

Reported to CMI by: ____________________ Date: ____________

Report completed by: ____________________ Date: ____________

Coal Mines Insurance Pty Limited. ABN 70 000 011 727

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