Coal Mines Insurance

Incident Involving:
1. Injury, no lost-time
2. Injury, lost-time
3. Fatality

Accident / incident form

To be completed by employer/supervisor of injured worker

EMPLOYER DETAILS

Name of Employer: _____ **Policy No:** _____ **ABN:** _____

Name of mine/location where injury occurred: _____

EMPLOYEE DETAILS

Name of employee: Surname: _____ Given Names: _____

Home address: _____ Postcode: _____

Date of birth: _____ Gender: Male ☐ Female ☐

Basis of employment: fulltime ☐ part time ☐ casual ☐ contract ☐ If contract, state period: _____

Occupation: _____ Base rate of pay: $ _____

Award/Agreement employee paid under: _____ Date employment commenced: _____

INJURY DETAILS

Date/time of incident: _____ am ☐ pm ☐ Day of week _____ on duty at workplace ☐ on journey while on duty ☐ on journey to or from work ☐

Date/time incident reported: _____ am ☐ pm ☐ To whom: _____ (name/position)

Time employee began work on day of incident: _____ am ☐ pm ☐

Did employee cease work before end of shift as result of injury? Yes ☐ No ☐ If yes, time ceased: _____ am ☐ pm ☐

Nature of injury (e.g. fracture, sprain): _____

Part of body injured (e.g. left upper arm, lower back): _____

Was treatment given at mine? Yes ☐ No ☐ If yes, by whom: _____ (name/position)

Describe treatment given: _____

Describe how incident occurred (attach sketch if necessary) : _____

_____

_____

_____

_____

_____

Coal Mines Insurance Pty Limited: ABN 70 000 011 727

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T: +61 (2) 4286 5430
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558-580 Princes Highway
Woonona NSW 2517
PO Box 212
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SHIFT DETAILS

Shift details: Shift on which incident occurred: day ☐ afternoon ☐ evening ☐ night ☐

Employee's shift basis: permanent ☐ rotating ☐ Was injured worker on overtime: Yes ☐ No ☐

Hours employee worked in previous 7 calendar days:	Day 1	2	3	4	5	6	7	8
Hours	☐	☐	☐	☐	☐	☐	☐	accident

JOURNEY INCIDENT DETAILS

If journey accident, indicate: on way to work ☐ on way home ☐ other journey ☐

If other journey, give details: _____

Time journey commenced: _____ am ☐ pm ☐ Usual duration of journey: _____ hrs. _____ mins

Type of transport used at time of accident: _____

Do you have any concerns with the circumstances surrounding the journey? _____

TREATMENT DETAILS

Has employee been absent from work for 1 full day or more after the day on which he was injured? Yes ☐ No ☐

Where did employee go after accident? return to work ☐ home ☐ to doctor ☐ to hospital, discharged ☐ to hospital, admitted ☐

Name of hospital: _____ Was ambulance called? Yes ☐ No ☐

Name of employee's doctor: _____ Recurrence of previous injury? Yes ☐ No ☐

OTHER DETAILS

Name(s) of any other employee(s) injured in accident: _____

Name(s) and address(s) of witness(s) to accident: _____

_____

In cases of serious injury, witness statements should be promptly forwarded to CMI

State other relevant information which may have a bearing on liability or which may assist in prompt settlement of claim (any statement of information will be treated as confidential): _____

_____

_____

_____

Attach copies of any written reports on the accident submitted to the Manager or to the Department of Trade & Investment, Regional Infrastructure & Services NSW. No compensation payment is to be made until the authority of Coal Mines Insurance has been obtained.

EMPLOYER'S DECLARATION

I: _____
(name and position)

declare that to the best of my knowledge and belief that the information provided herein is accurate.

Signature: _____ Date: _____

Privacy Statement: Information or opinions of this form that could reasonably identify an individual to another person are considered to be 'personal information' under the privacy legislation. CMI will only use or disclose personal information for the purposes that would reasonably be expected during the claim process, e.g. sharing information with other service providers, medical practitioners involved in this claim. If you would like any further information relating to CMI's privacy policy or have any concerns about how CMI is managing personal information, please contact our office on (02) 8270 3200.