

## **Employer's Incident Notification Form**

## **Notification Type:**

1. Report only	
2. Injury, no lost time	
3. Injury, lost time	
4 Fatality	

1. Employer de	tails			
Name of employer				To whom was the incident reported? (Name and position)
Policy number		ABN		Recorded on register of incidents? Yes ☐ No ☐
Name of mine/location	on where	incident occurred		Duty status  On duty at workplace On journey while on duty On journey or from work
worker's wages dec				Did worker cease work before end of shift as a result of injury?
Open Cut Mine		Underground Mine		Yes No
Administration Onsite		Administration Offsite		If yes, date and time ceased am ☐ pm ☐
Operational Mining Services Onsite		Operational Mining Services Offsite		Was treatment given at the workplace? Yes ☐ No ☐
2. Worker deta	ils			If yes, by whom? (name and position)
Title Surnam	ne		_	
Given name(s)		Other/previous legal n	names	Describe treatment given
Date of birth	Gender			Part of body injured e.g. left upper arm, psychological
	Male	Female Other	]	N
Home address				Nature of injury e.g. fracture, strain
				Describe how the incident occurred (attach sketch if necessary)
				details from the modern obtained (attach sketch in necessary)
Home phone numbe	r	Mobile phone number		
Email address				
Liliali addiess				
Basis of employmen	t			
	time 🗌	Casual		
Contract If co	ntract, st	ate period		
Occupation	·			
Award/Agreement w	orker paid	l under		
Base rate of pay (\$)	Da	ate employment comm	enced	
3. Incident deta	ails			Similar Exposure Group (SEG) at time of injury
Date of incident		Time of incident am p	om 🗌	Cilinal Exposure Group (GEG) at time of injury
Time worker comme		t on day of incident		Has the worker indicated they will be submitting a claim for workers compensation benefits?
Date incident report	ed	Time incident reporte		Yes
		am 🗌 p	om 📙	No  ☐▶ Go to Section 8

4. Shift details	Has worker undertaken any treatment for this injury?  E.g. Physiotherapy
Shift on which incident occurred  Day	Yes No
Worker's shift basis Permanent Rotating	If yes, provide details
Was worker injured on over time?	
Yes No	7. Other details
Hours worked in previous 7 calendar days  Day 1 2 3 4 5 6 7 8	Were there any other workers injured in the incident? Yes ☐ No ☐
Hours	If yes, provide name(s) and contact details
5. Journey incident	
This section should only be completed if the injury sustained is related	
to a journey incident.  Type of journey	Were there any witnesses to the incident? Yes ☐ No ☐
On way to work  On way home  Other	If yes, provide name(s) and contact details
If other journey, give details	
	In cases of serious injury, witness statements should be promptly forwarded to CMI.
Time journey commenced  am pm Hours  Minutes	Please attach any other information relevant to this incident. This may include written reports submitted to the Resource Regulator.
Mode of transport used	_
	8. Employer's declaration
Do you have any concerns with the circumstances surrounding the journey?	8. Employer's declaration  I, (name and position)
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