Blue = new additions ** = relocated
Red = deletions [text / text] = tick box choices

Document Details				
Existing title:	Accident/incident form	**Document title updated?**	Yes ☒	No ☐
Updated title:	Employer's Incident Notiication Form			

Existing fields	Changes	Comments
EMPLOYER DETAILS	**2. Employer details**	
Name of employer: Policy No: ABN: Name of mine/location where injury occurred: In your wages declaration what category were the injured worker's wages declared under: [Open Cut Mine / Underground Mine / Operational Mining Services Onsite / Operational Mining Services Offsite / Administration Onsite / Administration Offsite]	Name of employer: Policy No: ABN: Name of mine/location where injury incident occurred: In your wages declaration what category were the injured worker's wages declared under?: [Open Cut Mine / Underground Mine / Operational Mining Services Onsite / Operational Mining Services Offsite / Administration Onsite / Administration Offsite]	
EMPLOYEE DETAILS	**1. Personal details**	
Name of employee: Surname: Given names: Home address: Post code: 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:	Title Name of employee: Surname: *Home address: Post code: Given name(s): Other/previous legal names Date of birth: Gender: [Male / Female / Other] *Home address Home phone number Mobile phone number Email address Basis of employment: [fulltime / part time / casual / contract] If contract, state period: Occupation:	Addition of other names field to capture information such as worker's maiden name. Addition of 'other' option under gender in line with SIRA and most government body forms. Addition of email address field to streamline worker communication.

Blue = new additions ** = relocated
Red = deletions [text / text] = tick box choices

Existing fields	Changes	Comments
	**Base rate of pay: Award/Agreement employee worker paid under: **Base rate of pay ($) Date employment commenced:	
INJURY DETAILS	**3. Incident 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 a result of injury? [Yes / No] If yes, time work 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):	Date/time of incident: [am / pm] 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] Time incident reported [am / pm] To whom was the incident reported?: (name and /position) Recorded on register of incidents? [Yes / No] Time employee began work on day of incident: [am / pm] ***Duty status [On duty at workplace / On journey while on duty / On journey to or from work] Did employee worker cease work before end of shift as a result of injury? [Yes / No] If yes, date and time work 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 the workplace? [Yes / No] If yes, by whom?: (name and /position) Describe treatment given: *****Part of body injured e.g. left upper arm, psychological ****Nature of injury e.g. fracture, sprain Describe how incident occurred (attach sketch if necessary): Similar Exposure Group (SEG) at time of injury **Has the worker indicated they will be submitted a claim for workers compensation benefits? [Yes / No > Go to Section 8]**	SEG group field added for accurate industry reporting. All notification types (incident report only, early notification and duly made claim) to be lodged on this form. Field added (final question in this section, bolded) for employer to indicate notification type being lodged. Also assists CMI in clearly identifying which notification type to record on database.
SHIFT DETAILS	**4. Shift details**	
Shift details:	Shift details: Shift on which incident occurred: [dDay / aAfternoon / evening / nNight]	

Blue = new additions ** = relocated
Red = deletions [text / text] = tick box choices

<table>
<tr><th>Existing fields</th><th>Changes</th><th>Comments</th></tr>
<tr><td>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:<table><tr><td>Day</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td></tr><tr><td>Hours</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>accident</td></tr></table></td><td>Employee's Worker's shift basis: [pPermanent / rRotating]
Was injured worker injured on overtime over time: [Yes / No]
Hours employee worked in previous 7 calendar days:<table><tr><td>Day</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td></tr><tr><td>Hours</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>accident incident</td></tr></table></td><td></td></tr>
<tr><td>JOURNEY INCIDENT DETAILS</td><td>5. Journey incident</td><td></td></tr>
<tr><td>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?</td><td>This section should only be completed if the injury sustained is related to a journey incident.

If journey accident, indicate: Type of journey [oOn way to work / oOn way home / oOther journey]
If other journey, give details:
Time journey commenced: [am / pm]
Usual duration of journey:
__ hrs
__ mins
Type Mode of transport used at time of accident:
Do you have any concerns with the circumstances surrounding the journey? [Yes / No]
If yes, details</td><td></td></tr>
</table>

Blue = new additions ** = relocated
Red = deletions [text / text] = tick box choices

Existing fields	Changes	Comments
TREATMENT DETAILS	**6. 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]	Has employee been absent from work for 1 full day or more after the day on which he was injured the worker lost any time from work due to the injury? [Yes / No] Where did employee the worker go after accident incident? [rReturn to work / hHome / tTo doctor / tTo hospital, discharged / tTo hospital, admitted / Other e.g. crib/first aid room] Name of hospital: Was ambulance called? [Yes / No] Name of employee's worker's doctor: (provide practice name where applicable) Recurrence of previous injury? [Yes / No] Current capacity for work [Pre-injury duties / Some capacity for work / No capacity for work] Has worker undertaken any treatment for this injury? E.g. Physiotherapy [Yes / No] If yes, provide details	Captures more details about worker's capacity
OTHER DETAILS	**7. 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 payment of compensation is to be made until the authority of Coal Mines Insurance has been obtained.	Name(s) of any other employee(s) Were there any other workers injured in accident: the incident? [Yes / No] If yes, provide name(s) and contact details Were there any witnesses to the incident? [Yes / No] If yes, provide Nname(s) and address(s) contact details 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 payment of compensation is to be made until the authority of Coal Mines Insurance has been obtained. Please attach any other information relevant to this incident. This may include written reports submitted to the Resource Regulator.	

Blue = new additions ** = relocated
Red = deletions [text / text] = tick box choices

Existing fields	Changes	Comments
EMPLOYER'S DECLARATION	**8. Employer's delaration**	
I, __ (name and position) declare that to the best of my knowledge and belief that the information provided herein is accurate. Signature: Date:	I, __ (name and position) have read the information provided in this form. I declare that the information I have supplied in this form, and any attachment to this form is true and correct, to the best of my knowledge and belief that the information provided herein is accurate. I understand that making a false or misleading statement concerning a claim is punishable by law and I may be prosecuted. Signature: Date:	
Privacy Statement	**Privacy notice**	
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.	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. CMI collects personal information (including sensitive information and health information) for the purpose of processing, assessing and managing worker's compensation claims (Claim), including determining liability and whether the Claim is true. CMI is authorised to collect personal information under the *Workplace Injury Management and Workers Compensation Act 1998* (NSW). CMI handles personal and health information in accordance with the *Privacy Act 1988* (Cth) and the *Health Records and Information Privacy Act 2002* (NSW). A copy of our privacy policy is available on our website. If you would like any further information relating in relation to CMI's privacy policy or if you have any concerns about how CMI is managing personal information, please contact our office on (02) 8270 3200.	