Coal Mines Insurance

Employer's Incident Notification Form

Notification Type:

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

1. Employer details

Name of employer: Policyholder Underground Pty Ltd

Policy number: PXXX

ABN: 1233123123123

Name of mine/location where incident occurred: Policyholder Underground

In your wages declaration, what category were the worker's wages declared under?

- Open Cut Mine ☐
- Underground Mine ☑
- Administration Onsite ☐
- Administration Offsite ☐
- Operational Mining Services Onsite ☐
- Operational Mining Services Offsite ☐

2. Worker details

Title: Mr

Surname: Citizen

Given name(s): John

Other/previous legal names:

Date of birth: 19/05/1976

Gender: Male ☑ Female ☐ Other ☐

Home address: 5 Main Street, Bulga

Home phone number:

Mobile phone number: 04XXXXXXXX

Email address: citizenj@gmail.com

Basis of employment

Full time ☐ Part time ☐ Casual ☐

Contract ☐ If contract, state period:

Occupation: Miner

Award/Agreement worker paid under: Policyholder Underground Pty Ltd 2018

Base rate of pay ($): $44.60 p/h

Date employment commenced: 09/07/2000

3. Incident details

Date of incident: 22/02/2020

Time of incident: 10:50 am ☑ pm ☐

Time worker commenced shift on day of incident: 06:00 am ☑ pm ☐

Date incident reported: 22/02/2020

Time incident reported: 10:55 am ☑ pm ☐

To whom was the incident reported? (Name and position): Bob Cat, Deputy

Recorded on register of incidents? Yes ☑ No ☐

Duty status

On duty at workplace ☑ On journey while on duty ☐ On journey to or from work ☐

Did worker cease work before end of shift as a result of injury? Yes ☑ No ☐

If yes, date and time ceased: 22/02/2020 11:00 am ☑ pm ☐

Was treatment given at the workplace? Yes ☐ No ☑

If yes, by whom? (name and position):

Describe treatment given:

Part of body injured e.g. left upper arm, psychological: Lower back

Nature of injury e.g. fracture, strain: Strain

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

John strained his back lifting 6 inch piping off the pipe trailer

Similar Exposure Group (SEG) at time of injury: CSHU006

Has the worker indicated they will be submitting a claim for workers compensation benefits?

Yes ☑

No ☐ ▶ Go to Section 8

4. Shift details

Shift on which incident occurred
Day ☑ Afternoon ☐ Night ☐

Worker's shift basis
Permanent ☑ Rotating ☐

Was worker injured on over time?
Yes ☐ No ☑

Hours worked in previous 7 calendar days

Day	1	2	3	4	5	6	7	8
Hours							12	Incident

5. Journey incident

This section should only be completed if the injury sustained is related to a journey incident.

Type of journey
On way to work ☐ On way home ☐ Other ☐

If other journey, give details

Time journey commenced
am ☐ pm ☐

Usual duration of journey
Hours
Minutes

Mode of transport used

Do you have any concerns with the circumstances surrounding the journey?
Yes ☐ No ☐

If yes, details

6. Treatment details

Has the worker lost any time from work due to the injury?
Yes ☑ No ☐

Where did the worker go after incident?
Return to work ☐ Home ☐ To doctor ☑
To hospital, admitted ☐ To hospital, discharged ☐
Other e.g. crib/first aid room ☐

Name of hospital

Was an ambulance called?
Yes ☐ No ☐

Name of worker's doctor (provide practice name where applicable)
Dr Seuss

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

7. Other details

Were there any other workers injured in the incident?
Yes ☐ No ☑

If yes, provide name(s) and contact details

Were there any witnesses to the incident?
Yes ☐ No ☑

If yes, provide name(s) and contact details

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

Please attach any other information relevant to this incident. This may include written reports submitted to the Resource Regulator.

8. Employer's declaration

I, Em Ployer
(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. I understand that making a false or misleading statement concerning a claim is punishable by law and I may be prosecuted.

Signature

Date

Privacy notice: 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 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.