NSW GOVERNMENT Education & Communities

Employee incident or injury notification form

CONFIDENTIAL

Please note incidents can be notified by contacting the Hotline on 1800 811 523 (8am to 5:00pm)

Has the Employee:

1. Sought medical treatment? ☐ **Yes** ☐ No 2. Had any time off work? ☐ **Yes** ☐ **No**

NOTIFIABLE INCIDENT - ***If the incident meets any of the criteria below please call WHS Directorate on 1800 811 523 immediately.***
Based on the information available to you, do you believe that the incident is (tick if relevant):

Fatality	The death of a person	☐
Serious injury or illness requiring immediate treatment: Other serious injury or illness	• As an in-patient in hospital • Amputation • Serious head or eye injury or serious burn • Separation of skin from underlying tissue eg de-gloving or scalping • Spinal injury • Loss of bodily function • Serious laceration • Exposure to a substance, which requires medical treatment within 48 hrs • Prescribed illnesses directly attributable to work with micro-organisms, or involving treatment or care of a person, contact with human blood or body substance or contact with animals • The following zoonoses contracted through contact with animals: Q fever, anthrax, leptospirosis, brucellosis, Hendra virus, avian flu, psittacosis	☐
Dangerous incident exposing person to a serious risk to their health or safety emanating from an immediate or imminent exposure to:	• Uncontrolled escape, spillage or leakage of a substance • Uncontrolled implosion, explosion or fire • Uncontrolled escape of gas steam or pressured substance • Electric shock • Fall from height of any plant, substance or thing • Collapse, overturning, failure or malfunction of, or damage to, any plant that is required to be authorised for use in accordance with the regulations • Collapse or partial collapse of a structure, or excavation including shoring supporting an excavation • An inrush of water, mud or gas in an underground excavation or tunnel • Interruption of underground ventilation • Other events prescribed by the regulations	☐

DETAILS OF PERSON REPORTING THIS INCIDENT

Name of the person completing this form		Employee no		Phone no.	
Signature		Date		Occupation	
Has the Workplace manager/principal been notified of this incident?		☐ No ☐ Yes			
Name of Workplace manager/principal		Phone no		Mob	

INCIDENT /INJURY ILLNESS TYPE

Incident type	☐ Injury Illness	☐ Hazard	☐ Property damange
	☐ Near miss	☐ Non conformance	☐ Environmental damage
Injury/Illness type	☐ Lost time injury	☐ Medical treatment	☐ Incident only - no treatment received

FIRST AID DETAILS

Was first aid administered?	☐ No ☐ Yes	If **yes**, name of person giving first aid		Details of first aid performed	

TREATMENT DETAILS

Doctor/hospital		Phone		Fax	
Address				Post code	

INJURY/INCIDENT DETAILS

Who was this incident reported to?							
Description of incident/hazard (What, where, how)?							
Date of injury/incident:		Time		Date reported		Time reported	
Type of injury:	☐ Laceration/contusion/Superficial ☐ Fractures/Dislocation ☐ Sprains/strains ☐ Exposure to hazardous substances ☐ Psychological injury ☐ Other						
Body part injured:	☐ None						
Has the employee suffered a previous similar injury or illness?	☐ No ☐ Yes						
Is this incident an aggravation or recurrence of injury?	☐ No ☐ Yes						
Does the employee have any secondary employment?	☐ No ☐ Yes						

INJURED WORKER DETAILS

Last name				Employee no.	
First name		☐ Male ☐ Female		Date of birth	
Residential Address				Postcode	
Phone No	Home		Work	Mobile	
Work Location				Section/region	
Occupation				**Cost centre/ School code**	
☐ Permanent full-time ☐ Permanent part-time ☐ Temporary ☐ Casual				Employed hrs per week	

WITNESS DETAILS

Last name				Employee no.	
First name		☐ Male ☐ Female		Date of birth	
Residential address				Postcode	
Phone no.	Home		Work	Mobile	
Work location				Section/region	
Occupation				Cost centre/ School code	
☐ Employee ☐ Contractor ☐ Student ☐ Volunteer ☐ Visitor					

RETURN TO WORK

Has the employee taken any time off work?	☐ No ☐ Yes	Date and time ceased work	
Date returned to work:	**OR**	Anticipated return date:	
Employee is fit for	☐ Pre-injury duties ☐ Suitable duties ☐ Normal hours ☐ Reduced hours		
Office use only – Award			

*FORWARD COMPLETED FORM WITHIN 24 HOURS TO CLAIMS & ADMINISTRATION UNIT BY FAX ON (02) 9707 6233
*FILE COMPLETED FORM IN THE WORKPLACE *REGISTER OF INJURIES*