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WHS Incident Notification Form

PART A - Details of the incident

Name:

Email address:

Office Location

Contact phone number:

Industrial Relations

Workers' Comp Policy and Services

WHS Engagement and Policy Services

Specialised Health and Safety Services

WHS Compliance and Field Services

Electrical Safety Office

Business and Corporate Services

Office of the Deputy Director-General

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Time of incident:

Date of incident

Location of incident

Activity being undertaken

Brief description of incident/near miss

Names and contact details for witnesses to the incident

Was anyone injured?

YES (Complete Part B for each injured person)

NO

REPORT ONLY

Employee Name

Date:

I declare that the details provided above by me are true and correct.

Manager Name

Date:

I confirm that the abovenamed has reported the abovementioned incident to me.

This form is to be treated as CONFIDENTIAL. Please retain the original and forward a copy to: OIR-REHAB@oir.qld.gov.au for central recording and reporting.

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PART B - Details of Injury

Note: If more than one person has been injured in this incident, please attach an additional Part B for each injured person.

Details of Injured person

Name:

Gender:

Female

Male

Date of Birth

Contact Details

Work phone:

Home phone:

Mobile:

Email:

Relationship with OIR

OIR Employee Details

Position Title:

Business Unit:

Type of employment:

Work cycle

Will a WorkCover claim be lodged?

YES

NO

Unsure

Mechanism of Injury

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Body Location(s)

Body Part

Injury type

Treatment required (highest level only)

Employee name:

Date:

Employee position:

I declare that the details provided above by me are true and correct.

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