# WHS Incident Injury Notification Report

| SECTION A – REPORT INFORMATION | | | |
|---|---|---|---|
| Host Employer: | | Site of Incident: | |
| Type of Incident: | ☐ Injury / Illness ☐ Incident without Injury ☐ Near Miss ☐ Hazard | | |
| Damage to: | ☐ Property ☐ Environmental ☐ Plant | | |
| Date/Time of Incident: | ……/……/…… am/pm | Date / Time of Report: | ……/……/…… ……am/pm |
| Reported by: | | Phone: | |
| Reported to: | | Phone: | |

| SECTION B – INCIDENT INFORMATION |
|---|
| Summary of Incident: |
| |
| Details of Incident:<br>(*explain clearly how the incident occurred. Describe the events, conditions and activities that may have contributed to this incident. Describe the extent of damage (if any). Attach any photos, drawings or witness statements*) |
| |

| **Witness Details:** | | | |
|---|---|---|---|
| Witness 1 Name: | * | Phone: | |
| Witness 2 Name: | * | Phone: | |

** Please complete an **Incident – Witness Statement form** and send to Spinifex Recruiting along with this form*

| SECTION C – INJURY INFORMATION | | | |
|---|---|---|---|
| **Injured Person Name:** | | D.O.B: | |
| Address: | | Phone: | |
| Position: | | Payroll Company | Smalls GWS JHA |



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| Details of Injury: *(Describe the type of injury and the body location of the injury)* | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| Type of treatment administered: | ☐ None | ☐ First Aid | ☐ Medical** | ☐ Hospital ** | ☐ Other |
| Details of Treatment provided: | | | | | |
| | | | | | |
| Treatment Provider Contact Details:<br>Dr (name)…… Phone:…….<br>Physio ……. Phone:…….<br>Xray ……. Phone:…….<br>Other …… Phone:……. | | | | | |
| Did the injured worker return to work? (please circle) | **Y** | **N** | | | |
| If YES when? | | | | | |

*** Please ensure a Workcover Certificate of Capacity is obtained from the Medical Professional and send to Spinifex Recruiting along with this report.*

| **SECTION D – ACTIONS** |
|---|
| What **Immediate Action/s** were implemented to control this incident? |
| What **Action/s** need to be implemented to prevent this incident reoccurring? |

| Person completing this form: | | | | | |
|---|---|---|---|---|---|
| Name: | | Signature: | | Date: | ……/……/…… |
| Supervisor: | | | | | |
| Name: | | Signature: | | Date: | ……/……/…… |

| *OFFICE USE ONLY* | *Is this incident WorkCover reportable? Yes ☐ No ☐* |
|---|---|



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