Ph: (0455) 124 680
www.mfire.com.au   martyn@mfire.com.au
Licenced Fire Safety Adviser

WHS Incident Notification Form

Details of incident (e.g. to a worker or visitor) and treatment	
Date of incident	
Time of incident	☐ am ☐ pm
Nature of incident	☐ Near miss ☐ First Aid ☐ Medical treatment/doctor
Name of injured person	
Address	
Occupation	
Date of birth	
Telephone	
Employer	
Activity in which the person was engaged at the time of injury	
Exact site location where injury occurred	
Nature of injury – e.g. fracture, burn, sprain, foreign body in eye	
Body location of injury (indicate location of injury on the diagram)	RIGHT LEFT FRONT VIEW RIGHT REAR VIEW

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MFire Workplace Fire Safety
PO Box 64
BUDGEWOI NSW 2262
ABN 76 346 347 099

Treatment given on site		Name of treating person	
Referral for further treatment? Yes ☐ No ☐	Name of doctor or hospital	Work Cover medical certificate received? Yes ☐ No ☐	Attach copies
Injury management required? Yes ☐ No☐	Notify return to work coordinator	Name of return to work Coordinator	
Witness to incident (each witness may need to provide an account of what happened)			
Witness name		Witness contact	
Witness name		Witness contact	

Details Of Incident (e.g. Property, Plant Or Environmental Damage)		
Date of incident	Time of incident	☐ am ☐ pm
Location of incident		
Details of damage to Equipment or property		
Name of person who Received the report	Telephone	

Description of incident

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Immediate response actions (e.g. barricades, isolation of power) to stabilise the situation	
Reported to	
Reported to principal contractor? Yes ☐ No ☐	Provide details (when, reported to and reported by):
Reported to authorities Yes ☐ No ☐	Provide details (when, reported to and reported by):
Reported to principal contractor? Yes ☐ No ☐	Provide details (when, reported to and reported by):
Reported to workers compensation insurer? Yes ☐ No ☐	Provide details (when, reported to and reported by):

Completed by			
Name		Position	
Signature		Date	

Copies to: [ ] Insurance Company on this date: / /

[ ] Employer on this date: / /

Any other person / entity as per employer requirements:

Name: ______________________________ on this date: / /

Position: ____