

SAFETY ALERT



Incident Notification

Today's Date: _____

Date of Incident: _____

Time of Incident: _____

Incident Type: Notifiable Near Miss Fatality Injury

Site Name (if applicable) _____

& Address: _____

Principal Contractor: _____

Contact Person: _____ Phone: _____

Sub-contractor: _____

Contact Person: _____ Phone: _____

Delegate/HSR: _____ Phone: _____

Area Organiser: _____

Cause of Incident (Please put 1 for Primary Cause and 2 for Secondary Cause)

- | | | |
|--|--|---|
| <input type="checkbox"/> Access/Egress | <input type="checkbox"/> Emergency | <input type="checkbox"/> Noise |
| <input type="checkbox"/> Air Quality | <input type="checkbox"/> Engineering | <input type="checkbox"/> Piling |
| <input type="checkbox"/> Amenities/Hygiene | <input type="checkbox"/> EWP | <input type="checkbox"/> Plant |
| <input type="checkbox"/> Asbestos | <input type="checkbox"/> Excavation | <input type="checkbox"/> Power Tools |
| <input type="checkbox"/> Chemicals | <input type="checkbox"/> Falling Objects | <input type="checkbox"/> Precast/Tilt Up Panels |
| <input type="checkbox"/> Concrete Pump | <input type="checkbox"/> Falls | <input type="checkbox"/> Pre-stressing |
| <input type="checkbox"/> Confined Spaces | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Post Tensioning |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Fire | <input type="checkbox"/> Radiation |
| <input type="checkbox"/> Contamination | <input type="checkbox"/> Formwork | <input type="checkbox"/> Rigging |
| <input type="checkbox"/> Core Drilling/Cutting | <input type="checkbox"/> Housekeeping | <input type="checkbox"/> Scaffold |
| <input type="checkbox"/> Cranes | <input type="checkbox"/> HSR/Committee | <input type="checkbox"/> Supervision |
| <input type="checkbox"/> Demolition | <input type="checkbox"/> Lifts & Hoists | <input type="checkbox"/> Synthetic Mineral Fibres |
| <input type="checkbox"/> Dust | <input type="checkbox"/> Lighting | <input type="checkbox"/> Traffic Management |
| <input type="checkbox"/> Electrical | <input type="checkbox"/> Manual Handling | <input type="checkbox"/> Training |

Incident Notification

Brief Description of Incident: _____

Injury Treatment: N/A First Aid on site Doctor/Hospitalisation

Name of Injured Worker: _____ **Phone:** _____

D.O.B: _____ Address: _____

Employer: _____ Phone: _____

RTW Plan? Yes No RTW Representative: _____

At the time of the Incident:

Weather: Cold Fine Hot Wet Windy
Was it a High Risk Task? Yes No
Was there a SWMS? Yes No N/A
Was the SWMS followed? Yes No N/A
Was SafeWork notified? Yes No N/A

Outcomes/Solutions to the Incident: _____

Form completed by: _____ **Phone:** _____

Please return this form to the CFMEU Work Health Safety Department
Email – safety@nsw.cfmeu.asn.au or Fax – **02 9749 3622**

Authorised by Brian Parker, Secretary CFMEU NSW.

Office ID: _____

