FORM

Incident Notification Form

NT WorkSafe must be notified of the occurrence as soon as practicable by the PCBU on 1800 019 115. You will be given an incident notification Reference Number that must be included on this form. This number is proof of your notification phone call as soon as was practicable.

Sections 35 to 39 of the *Work Health and Safety (National Uniform Legislation) Act 2011* (WHS Act).

In addition to immediate (as soon as is practicable) phone notification, this 2-page notification form must be faxed or emailed to NT WorkSafe within **48 hours** after the incident occurrence. Fax: **08 8999 5141**. Email: ntworksafe@nt.gov.au

For more information please see NT WorkSafe bulletin Incident Notifications.

Reference Number:		**Date:**	

Person Submitting Details (if completing form by hand, please print in BLOCK letters)					
Name:				Gender:	☐ Male ☐ Female
Position Title:					
Name of Employer/Self Employed Person notifying:				ABN:	
Business Address: (Not Postal Address)	Lot/Unit No.	Street No.	Street Name.	Suburb	City
Mobile:				Phone:	
Email:				Fax:	

Incident Details					
Date of Incident:	/ /			Time of Incident:	: ☐ am ☐ pm
☐ Death of a person	☐ Serious injury or illness		☐ Dangerous incident		
Name of Employer of any Injured or Deceased Person(s) if different from above:					
Address or location where the incident occurred:	Lot/Unit No.	Street No.	Street Name.	Suburb	City
Describe the specific location of the incident:					

Details of Injured/Deceased Person(s):					
Name:				Gender:	☐ Male ☐ Female
Date of Birth:	/ /	Occupation/Job Title:			
☐ Direct Worker	☐ Contractor	☐ Member of Public	☐ Other		
Residential Address:	Lot/Unit No.	Street No.	Street Name.	Suburb	City
Phone:				Mobile:	
Fax:				Email:	

Please complete all information overleaf ↳

Incident Description

Work activity being undertaken at the time of the incident (identify any plant, substance equipment involved) and a brief description of the incident:

Brief description of any injury/illness:

Did the person receive treatment following the injury/illness?	☐ No ☐ Yes If yes, describe treatment received below:

Name of person(s) who saw the incident or was first on the scene:

Action taken/intended, if any, to prevent recurrence of the incident:

Describe any longer term action proposed to prevent a recurrence:

Notification Date:	/ /	Signed:	☐ I have submitted this form electronically (signature is not required)