



Australian Government
Comcare

NOTIFICATION OF AN INCIDENT FACSIMILE TRANSMISSION

For use by Comcare staff only:

Grade
Incident No
Date entered
Name

THIS FORM IS TO BE COMPLETED BY A SUPERVISOR OR MANAGER

Employer:

Employee's Workplace: **State:**

Street Address: **Postcode:**

This incident is a: Death Serious Personal Injury Dangerous Occurrence Incapacity

Time of Incident: am/pm **Date of Incident:**

Location/address where Incident occurred: **State:**

(if different from above) **Postcode:**

Is this location a major hazard facility? Yes No

Details of Incident:

Describe how the incident occurred and include: exact location of the incident within the workplace (eg desk, stairs); details of any plant and equipment involved; the process or substance involved:

(attach separate sheet if insufficient space)

Details of injury/injuries received:

Name of person/s killed, seriously injured or incapacitated

First name: **Surname:**

(if more than one person attach a separate sheet)

Action that the employer has taken or proposes to take to prevent a recurrence of a similar incident:

Details of supervisor or manager completing this form:

Name: **Title:**

Designation: **Contact telephone number:**