



Schedule 2 — Forms relating to general provisions  
Form 1 — NOTIFICATION OF INJURY

Occupational Safety and Health Act 1984

[Regulation 2.4(2)]

WorkSafe Western Australia Commissioner  
Locked Bag 14  
CLOISTERS SQUARE PERTH WA 6850  
Phone: 1300 307 877 Fax: (08) 6251 2824  
Email: wscallcentre@commerce.wa.gov.au

INJURY REPORTING TELEPHONES:  
(08) 6251 2200  
1800 678 198

PLEASE USE CAPITAL LETTERS  
PLEASE NOTE: ONLY EMPLOYERS CAN REPORT INJURIES TO WORKSAFE

Section 1: Employer details			
Legal name:			
Trading name:		ABN / ACN:	
Type of workplace:		ANZIC:	
Street address:			
Suburb/Town:		Postcode:	
Phone:		Fax:	
Email:			

Section 2: Details of injured person			
Surname:		Sex: Male <input type="checkbox"/>	Female <input type="checkbox"/>
Given names:			
Occupation:			
Date of birth: / /	Age:	Days unable to work:	

Body Location		Injury Codes
Skull	A	
Chest	B	
Arm	C	
Leg	D	
Digit (finger/toe)	E	
Pelvis	F	
Spine	G	
Eye	H	
Ankle/Foot	I	
Injury Type		
Amputation	1	
Fracture	2	
Laceration	3	
Loss of sight	4	
Other 10 days +	5	
Fatality	6	

**Examples:**  
1. Head fracture would be an A2  
2. Arm amputation would be a C1  
3. Toe amputation would be an E1

Section 3: Details of injury			
Date of injury: / /	Time of injury:	:	<input type="checkbox"/> am <input type="checkbox"/> pm
WorkCover number:			
Nature of injury:			
Injury code			
Brief description of how injury occurred:			
Address of the workplace where the injury occurred:	Street address:		
	Suburb/Town:		
	Postcode:		
Area of workplace the injury occurred:			
Person removed to:			
Name of person reporting injury to WorkSafe.	First name:		Surname:
	Position:		Phone:
Person for liaison:	First name:		Surname:
	Position:		Phone:

OFFICE USE ONLY:

DATE: \_\_\_ / \_\_\_ / \_\_\_\_\_ TIME: \_\_\_\_\_ SAVED TO OBJECTIVE:  OFFICER: \_\_\_\_\_ A3026607