



# Notice of accident / serious harm

Check that the details on this copy are complete and forward it to your nearest OSH office

DEPARTMENT OF  
**LABOUR**  
TE TARI MAHI

## 1 Particulars of employer: (Business name and address)


## 2 Location of place of work:


Shop, shed, unit no, floor, building; Street no and name; Locality / suburb

## 3 Personal data of injured person:

Name	
Residential address	

Date of birth  Sex (M/F)

## 4 Occupation or job title of injured person:

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## 5 Period of employment of injured person:

- 1<sup>st</sup> week       1<sup>st</sup> month       1-6 months  
 6 months-1year       1-5 years       Over 5 years  
 non-employee

## 6 Treatment of injury:

- Nil       First-aid       Doctor (not hospitalised)  
 Hospitalised

## 7 Time and date of accident/serious harm:

Time  am/pm

Date

Shift  Day       Afternoon       Night

Hours worked since arrival at work

## 8 Mechanism of accident/serious harm:

- Fall, trip or slip       Hitting objects with part of the body  
 Sound or pressure       Being hit by moving objects  
 Body stressing       Heat, radiation or energy  
 Biological factors       Chemicals or other substances  
 Mental stress

## 9 Agency of accident/serious harm:

- Machinery or (mainly) fixed plant  
 Mobile plant or transport  
 Powered equipment, tools or appliances  
 Non-powered handtools, appliances and equipment  
 Chemical or chemical products  
 Material or substance  
 Environmental agency  
 Animal, human or biological agency (not bacteria or virus)  
 Bacterial or virus

## 10 Body part:

- Head       Neck       Trunk  
 Upper limb       Lower limbs       Multiple locations  
 Systemic (internal organs)

## 11 Nature of injury or disease: (specify all)

- Fatal
- |  |   |
|--|---|
| <input type="checkbox"/> Fracture of spine         | <input type="checkbox"/> Puncture wound                   |
| <input type="checkbox"/> Other fractures           | <input type="checkbox"/> Poisoning and toxic effects      |
| <input type="checkbox"/> Dislocation               | <input type="checkbox"/> Multiple injuries                |
| <input type="checkbox"/> Sprain or strain          | <input type="checkbox"/> Damage to artificial aid         |
| <input type="checkbox"/> Head injury               | <input type="checkbox"/> Disease, nervous system          |
| <input type="checkbox"/> Internal injury of trunk  | <input type="checkbox"/> Disease, musculoskeletal         |
| <input type="checkbox"/> Amputation, incl. eye     | <input type="checkbox"/> Disease, skin                    |
| <input type="checkbox"/> Open wound                | <input type="checkbox"/> Disease, digestive system        |
| <input type="checkbox"/> Superficial injury        | <input type="checkbox"/> Disease, infectious or parasitic |
| <input type="checkbox"/> Bruising or crushing      | <input type="checkbox"/> Disease, respiratory system      |
| <input type="checkbox"/> Foreign body              | <input type="checkbox"/> Disease, circulatory system      |
| <input type="checkbox"/> Burns                     | <input type="checkbox"/> Tumour (malignant or benign)     |
| <input type="checkbox"/> Nerves or spinal cord     | <input type="checkbox"/> Mental disorder                  |
| <input type="checkbox"/> Occupational hearing loss |   |

## 12 Where and how did the accident/harm happen?

If not enough room, attach separate sheet or sheets

- 13 Has an investigation been carried out?**      yes/no  
Was a significant hazard involved?      yes/no

**Completed by:** Employer or employer's representative (delete which is not applicable)

Name and position

Signature

Date

