



## INITIAL INCIDENT NOTIFICATION FORM

for the purpose of Workplace Safety and Health (Incident Reporting) Regulations, 2014

Ref. No.

### INFORMATION ABOUT THE INCIDENT

Location of Incident

Date of Incident

Time of Incident

Reported to the Police  
Officer

No.

Yes

Reference:

### INFORMATION ABOUT REPORTER

Name

Name of Company

Address

Position

IC No.

Tel No.

### INFORMATION ABOUT RECEIVING OFFICER IN-CHARGE (to be completed by Authority)

Date Reported

Time Reported

Received by Name

Received by phone  
No

### RESULTS OF INCIDENT

Fatality

Property Damage

First Aid

Doctor's Treatment

Hospital In-Patient

Others

Notes:

<b>INFORMATION ABOUT FATALITIES, DAMAGE ASSET AND SPILL DETAILS (if applicable)</b>			
Number of Fatalities		Number of Injured Person (IP)	
Injury Sustained			
Description of damaged asset			
Source of oil/chemical spill or gas			
Cause of spill/gas release			
Volume of oil/chemical spill or gas release (m3/bbls)			
Other			
<b>DETAILS OF INCIDENT/ACCIDENT</b>			
<b>INFORMATION ABOUT THE PERSON INVOLVE IN THE INCIDENT/ACCIDENT</b>			
Name of Injured Person			
Address			
Tel. No.		IC No.	Nationality
Gender		Date of Birth	
<b>ACTION TAKEN BY EMPLOYER / SUPERVISOR OFFICER</b>			

**ACTION TAKEN BY REGULATOR**

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**To be completed by Authority**

<input type="checkbox"/> No Action	<input type="checkbox"/> Monitor	<input type="checkbox"/> Investigation
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\*tick as appropriate

STATUS	DATE	SIGNED	COMMENT
Open			
Closed			