INJURED WORKER'S DETAILS

1 Title (Mr/Mrs/Miss/Ms)

2 Surname

3 Given names

4 Residential address

Postcode:

5 Postal address *(if different from residential)*

Postcode:

6 Daytime contact phone numbers

M | W | H

7 E-mail address

8 Date of birth ...../...../.....

9 Gender Male ☐ Female ☐

10 Country of birth Australia ☐ Overseas ☐

If overseas print country of birth *Office Use*

11 If you have difficulty understanding English, what is your preferred language? *Office Use*

Incident & Worker's Injury Details

12 Date and time injury or condition occurred ...../...../..... : am/pm

If different, date injury or condition first noticed ...../...../.....

13 Describe how the injury or condition occurred *Office Use*

(i) Give the details of what happened, how it happened and what was involved, *e.g. knocked off ladder by tractor and tractor ran over legs; inhaling asbestos fibres when demolishing old buildings* — *Mech*

Agency of Injury

B/down Agency of Injury

(ii) What was/were the most serious type(s) of injury or disease caused by this occurrence? *e.g. burn; cut; fracture; hernia* — *Injury*

(iii) What part of the body was most seriously affected by this occurrence? *e.g. upper arm; left ankle; right eye; upper back* — *POB*

You must attach a workers compensation medical certificate to this claim

14 Address where injury or condition occurred?

Postcode:

15 If stopped work, what was the date and time? ...../...../..... : am/pm

16 Date and time started work on the day or shift of the injury or condition occurring ...../...../..... : am/pm

17 Where did your injury or condition occur?

At work—working at normal workplace ☐
At work—road traffic accident ☐
At work—on break ☐
At work—working away from normal workplace ☐
Away from work during recess period ☐
Travelling to or from work ☐
Commuting/journey (excluding travelling to or from work) ☐

18 Is your injury or condition solely due to this occurrence? No ☐ Yes ☐

If no, give details below

19 Name of medical practitioner who provided immediate treatment

20 Name of treating practice or hospital

21 If treated at a hospital, were you admitted as an inpatient? No ☐ Yes ☐

22 Did you have any other employment at the time your injury or condition occurred? *If yes, give details below* No ☐ Yes ☐

Worker's Medical Authority

NOTE: You do not have to complete this Authority. However, not doing so may mean delays to your claim being finalised.

To any medical practitioner or other person who has treated me, or the Registrar of any hospital at which I have received treatment.

I, employed by

authorise any medical practitioner or any other person who has treated me or the Registrar of any hospital at which I have received treatment to give my employer, or his insurer, information about myself specific to this claim for workers compensation. A photocopy of this authority is to be considered as valid as the original.

23 Your signature

24 Date signed ...../...../.....

25 Name of primary treating medical practitioner *(providing primary medical care)*

26 Contact details of primary treating medical practitioner *(practice name)*

Worker's Declaration

The *Workers Rehabilitation and Compensation Act 1988* imposes heavy penalties for giving false or misleading information.

I declare that to the best of my knowledge and belief, all the information given in this form is true and correct in every particular.

27 Your signature

28 Date signed ...../...../.....

29 Witness to signature

Notification and Witnesses

30 Name of person notified

31 Date and time notified ...../...../..... : am/pm

32 Your supervisor's name

33 Name of any witnesses to the occurrence

4 Date claim form and workers compensation medical certificate given to employer

claim form ...../...../.....

medical certificate ...../...../.....

Previous Claims

5 Have you made any claims before? No ☐ Yes ☐

If yes, give details below

EMPLOYER'S DETAILS

6 Employer's legal name, i.e. Registered Company Name, State Government Department, Partnership, Sole Trader's Name

e.g. J Citizen Pty Ltd, Department of Education

7 Australian Business Number (ABN)

8 Employer's address

Postcode:

9 Employer's trading name or Division in State Government Department

e.g. J Citizen's Laundromat Primary Education

10 Industry of employer *e.g. dry-cleaning services, dental sevices*

11 Number of full-time equivalent workers *(see front page for explanation)*

Treatment and Return to Work Details

12 Does the worker's medical certificate indicate a need for rehabilitation? No ☐ Yes ☐

13 Have you been contacted by the worker's treating medical practitioner to discuss treatment and/or return to work options? No ☐ Yes ☐

14 Can suitable duties be provided? No ☐ Yes ☐

15 What is the worker's estimated time off work?

No lost time ☐

Less than 6 days ☐

(Injury Management Co-ordinator to be appointed & Return to Work Plan to be developed) 6 to 14 days ☐ / 15 to 27 days ☐

(Injury Management Co-ordinator to be appointed & Injury Management Plan to be developed) 28 days or more but less than 3 months ☐ / More than 3 months ☐

Worker's Employment Details

16 Normal weekly earnings *(see front page for explanation)* $

17 Ordinary time rate of pay per week *(see front page for explanation)* $

18 Normal weekly hours *(see front page for explanation)* (hrs)..... (mins).....

19 Average days usually worked per week

20 Worker's occupation at time injury or condition occurred *Office Use*

21 Department or section where injury or condition occurred *e.g dispatch, warehouse, sales* *Office Use*

22 Date the worker started in your employment ...../...../.....

Office Use

53 Is the worker a:

Direct employee ☐ Sub contractor ☐

Working director ☐ Labour hire worker ☐

Contractor ☐ Apprentice/trainee ☐

Worker of contractor ☐ Other ☐

If 'other' give details below e.g. in training program, police volunteer, fire fighting/fire prevention operations

54 Is the worker a:

Permanent employee ☐ Temporary employee ☐

Casual employee ☐ Temporary overseas visa worker ☐

55 If applicable, is the worker: Full-time ☐ Part-time ☐

56 Date insurer notified of injury *(see front page for explanation)* ...../...../.....

57 Date insurer notified of claim *(see front page for explanation)* ...../...../.....

58 Date claim lodged with insurer *(see front page for explanation)* ...../...../.....

59 Date of next payday following the date of claim receipt ...../...../.....

Employer Contact Information

Please give the name of someone who can be contacted for additional information about this claim

60 Contact name

61 Position

62 Contact phone

Employer Certification

The Workers Rehabilitation and Compensation law imposes heavy penalties for giving false or misleading information.

I am satisfied that the information given on this form is true and correct ☐

I believe that further investigation into this claim is required ☐

63 Employer representative's signature

64 Date signed ...../...../.....

65 Name of representative

66 Position

INSURER'S DETAILS

Policy and Claim Details

67 Insurer name *Office Use*

68 Policy number

69 ANZSIC classification of policy

70 Claim number

71 Claim type

New ☐ Re-opened ☐ If re-opened tick below

Aggravation ☐ Recurrence ☐ Other ☐

If 'other' give details below

72 Date claim received by insurer ...../...../.....

(For self-insurers this date will be the same as shown in question 58)