This form can be used to lodge a Workers' Compensation Claim in New South Wales, Queensland, or Victoria

WorkCover NEW SOUTH WALES

WorkCover QUEENSLAND

WorkSafe VICTORIA

WORKER'S INJURY CLAIM FORM

Please indicate in which State you want to lodge this claim:

☐ *New South Wales* ☐ *Queensland* ☐ *Victoria*

1 WORKER'S PERSONAL DETAILS

Title | Family Name

Given names

Other known or previous legal names *eg. Maiden name*

Date of birth / / | Gender ☐ Male ☐ Female

Residential street address

Suburb

State | Postcode

Postal address for correspondence

What are your daytime contact phone number/s?

M | W | H

E-mail address

If you need an interpreter, what language do you speak?

Do you have special communication needs because of disability? *eg. Hearing or vision impairment*

** These questions are required for NSW claims*

* Do you support a partner? ☐ Yes ☐ No

* If yes, what were their average gross weekly earnings over 3 months? $

* Do you support any children under the age of 18, or full-time students? ☐ Yes ☐ No

* If yes, please provide the date of birth for each

2 INCIDENT & WORKER'S INJURY DETAILS

What is your injury/condition, and which parts of your body are affected?

What happened and how were you injured?

What task/s were you doing when you were injured?

What area of the worksite were you working in when you were injured?

What is the street address where the incident occurred?

Suburb

State

Name of employer responsible for this workplace

Which of the following incident circumstances apply?

☐ *While working at your usual workplace*

☐ *While working away from your usual workplace*

☐ *During a meal-break or authorised recess at work*

☐ *While away from work during a recess*

☐ *Travelling to or from work**

☐ *A motor vehicle accident while you were working**

** For NSW incidents a journey claim form must also be completed*

If your injury was the result of driving or using a motor vehicle or the use of public transport, please provide the following details:

The police station the accident was reported to

Registration number/s of involved vehicles | State

Do you believe that your injury/condition was caused or contributed to by a third party such as a manufacturer or supplier? *Please give details if relevant*

What was the date and time the injury/condition occurred?

/ / AM PM

When did you first notice the injury/condition?

/ /

If you stopped work, what was the date and time?

/ / AM PM

When did you report the injury/condition to your employer?

/ /

What is the name and position of the person you reported the injury/condition to?

If you did not report the injury/condition, or there was a delay, please explain why

What are the names and daytime contact details of anyone who witnessed the incident?

Have you previously had another injury/condition or personal injury claim that relates to this injury/condition?

Please give details, including claim numbers

3 WORKER'S EMPLOYMENT DETAILS

Name of organisation paying your wages when you were injured

Street address of your usual workplace

Suburb

State | Postcode

Name and daytime contact number of employer contact
eg. Name of return to work coordinator

What is your usual occupation? *What do you do?*

Which of the following apply to you?
(Please tick all relevant boxes)

☐ Full-Time ☐ Part-Time ☐ Casual ☐ Student
☐ Contract ☐ Trainee ☐ Apprentice ☐ Volunteer
☐ Permanent ☐ Temporary ☐ Seasonal ☐ Jockey
☐ Agency worker ☐ Contractor

Other?

When did you start working for this employer?
/ /

Please indicate if any of the following apply to you:

☐ Yes ☐ No *A Director of my employer's company*
☐ Yes ☐ No *A Partner in my employer's company*
☐ Yes ☐ No *A sole trader*
☐ Yes ☐ No *A relative of my employer*

Did you have any other employment at the time you were injured? *Please provide or attach the names of any other employers and their contact details, and any relevant wage or payment records*

4 WORKER'S PRIMARY EARNING DETAILS

Please complete this section if you wish to claim for weekly payments

How many standard hours did you work each week before being injured? *Exclude overtime* hrs

What were your usual working hours?
For example, Monday to Friday, 8.30 am to 5.30 pm

What was your usual pre-tax hourly rate?*
Exclude overtime & shift allowances $

What were your usual pre-tax weekly earnings?*
Exclude overtime & shift allowances
** Please provide copies of any recent payslips (if available)* $

Please provide details of any overtime or shift work

Weekly shift allowance $

Weekly overtime hrs $

5 TREATMENT & RETURN TO WORK DETAILS

** This question is required for NSW claims*
* Who is your nominated treating doctor?
Name | Phone

Please provide the name, clinic or hospital, and contact details of any medical providers (including Clinics or Hospitals) that have treated your injury

If you have returned to work with your employer, what was the date? / /

What duties are you doing? ☐ *Full* ☐ *Suitable/Modified*

How many hours are you working? hrs

Have you returned to work with a new employer?
Please provide the name and contact details of the new employer

If you have not returned to work, do you think that there are any issues that would delay or prevent you from returning to work?

When did/will you give your employer this claim form?
/ /

How did/will you give this claim form to your employer?
☐ *Hand delivery* ☐ *By post*

When did/will you give your employer the first medical certificate?
/ /

6 AUTHORITY TO RELEASE MEDICAL INFORMATION AND WORKER'S DECLARATION

I have read the information provided in this form. I declare that the information that I have supplied in this form, and any attachments to this form, is true and correct to the best of my knowledge. I understand that the making of a false or misleading claim or false and misleading statement in support of the claim is punishable by law and that I may be prosecuted.
I authorise and consent to any person who provides a medical service or hospital service to me in connection with an injury/condition to which this claim relates to provide upon request by the workers' compensation authority, my employer or insurer/claims agent, any information regarding the service relevant to the claim. I understand that my authority has effect and cannot be revoked for the duration of this claim.

Worker's signature | Date / /

** This declaration is also required for NSW claims*
I authorise and consent to the collection, disclosure and release of any personal and health information in connection with an injury/condition to which the claim relates by the workers' compensation authority, my employer or insurer/claims agent to each other, or to any person who provides a medical service or hospital service to me in connection with an injury/condition to which this claim relates. I understand that if this claim results in my receiving weekly compensation payments, I am required to notify whomever is paying my benefits if I commence employment with some other person or in my own business, or of any change in my employment that affects my earnings, and that failure to do so is an offence. I consent to the WorkCover Authority of NSW using the information collected in connection with my claim for the purposes of research about workers compensation, workplace injury management and occupational health and safety.

Worker's signature | Date / /

7 EMPLOYER LODGEMENT DETAILS

When did the employer first receive the worker's completed claim form? / /

When did the employer first receive the worker's medical certificate? / /

**This question is required for Victorian claims*
Date claim form forwarded to Agent / /

Estimated cost of claim to date $

How many days have been lost? days hrs

Employer's signature | Date / /

Name

Position

Employer's scheme registration number
eg. WorkCover Employer, Policy, or Employer Registration Number

ORIGINAL