QBE Connect®

Injury Management Handbook

Western Australia

Workers Compensation

QBE is committed to working with employers to assist them with the successful and timely return to work of injured workers. To this end, QBE has developed an Injury Management Handbook. *The Workers Compensation and Injury Management Act 1981* (the Act) requires all employers in Western Australia to have a documented workplace injury management system and to develop return to work programs for injured workers. This handbook provides the resources to assist employers to fulfil these obligations. For assistance please contact your local QBE office or call your QBE Case Manager.

- **Injury Management System Flow Chart**
- **Injury Management Policy Template**
- **Injury Management System Template**
- **Return to Work Programs – Important Information for Employers**
- **Return to Work Program Template**
- **Employer's Report of Injury**
- **Workers Compensation Claim Form**

QBE

December 2010 QM2865-1210

Injury Management System Flowchart

1 The injured worker notifies the employer of injury. First aid is provided by a trained first aid officer. An appointment is arranged with a doctor and the incident is documented. In the event of a significant injury, QBE is notified by telephone.

2 Where possible the employer representative accompanies the injured worker to the medical appointment.

3 A First Medical Certificate is issued by the doctor. At this appointment discussions regarding return to work options may occur.

A Return to Work (RTW) Program may be developed at this point and signed by the worker, employer and doctor.

4 The injured worker completes a Workers Compensation Claim Form provided by the employer.

Once completed, signed and witnessed the worker provides the claim form and First Medical Certificate to the employer.

5 The employer completes the QBE Employers Report of Injury form. A photocopy of the completed claim form, First Medical Certificate and Employers Report form are retained for the employer's records. The original documents are sent to QBE within three working days.

6 The employer maintains contact with the injured worker, their treating doctor and QBE to ensure that a return to work outcome is achieved. The injured worker is given the opportunity to participate in the development and review of the return to work program.

Important Information

- The injured worker has the right to choose their treating doctor and allied health provider.
- A return to work program must be developed when the treating doctor requests that one be developed or when the worker is certified fit for restricted duties.
- An injured worker must be given the opportunity to participate in the development of their return to work program.
- An employer must notify WorkSafe WA of certain work related injuries and diseases. For more information contact WorkSafe WA on 1800 678 198 or log on to *www.worksafe.wa.gov.au*

Injury Management Policy

Business Name	

We are committed to assisting injured workers to return to work as soon as medically appropriate and in the event of a work related injury or illness will adhere to the requirements of:

» **The *Workers Compensation and Injury Management Act 1981* and**

» **The *Code of Practice (Injury Management 2005)*.**

Management supports the injury management process and recognises that its success relies on the active participation and cooperation of the injured worker, their treating doctor and the employer. In the event of a workplace injury or illness, we will follow the steps outlined in the Injury Management System. A copy of the Injury Management System available to all staff on request.

We value early reporting of injuries so that the injury management system may be applied at the earliest opportunity.

We are committed to ensuring that the focus of injury management is the safe and durable return to work of injured workers. Wherever possible, suitable duties will be arranged internally having regard for the injured worker's medical restrictions. Where this is not immediately possible, we remain committed to ensuring injured workers achieve the most appropriate return to work outcome.

Contact Person			
Position Title			
Telephone			
Employer Signature	**X**	Date	

Injury Management System

Business Name	

Aim of the Injury Management System:

- **To ensure that we respond to Workers Compensation claims in an appropriate manner and without undue delay.**
- **To ensure that injured workers are able to access medical treatment and advice as soon as practicable and can remain at work or return to work at the earliest appropriate time.**

Injury Management Policy

Our approach to injury management is set out in the Injury Management Policy. This is available to all staff.

Injury Management Steps

- Staff should report any injury sustained whilst at work as soon as possible to their direct supervisor or manager, or in their absence to an available member of the management team.
- An injured staff member will be provided with first-aid by a qualified first-aid representative.
- An injured staff member will be informed of their right to choose their own medical provider.
- Where practicable and appropriate, we will arrange transportation and accompany the injured staff member to the initial doctor's appointment in order to be fully informed of the treatment and return to work requirements.
- When a staff member has sustained an injury and received a First Medical Certificate for a work related injury, we will provide a Workers Compensation Claim Form (Form 2B).
- When a completed workers compensation claim form and the First Medical Certificate is received from the injured member of staff, we will send the documents to our workers compensation insurer within three working days in accordance with the *Workers Compensation and Injury Management Act 1981* (the Act).
- We will discuss the workers compensation claim with the insurer, to clarify any issues or concerns or request up-to-date information about our responsibilities in relation to the claim.
- We will maintain close contact with the injured member of staff to check on progress and make arrangements so that they may either remain at work or return to work as soon as medically appropriate.
- If it is required, a return to work program will be established in consultation with the injured member of staff and in accordance with the Act.
- Where it is deemed necessary, the assistance of an approved vocational rehabilitation provider may be enlisted.

Worker Participation

For a workers compensation claim to be processed, an injured staff member must provide a completed claim form and submit all medical certificates issued by the treating medical practitioner.

Injured staff members should maintain close contact with their supervisor to provide information on their progress and participate in return to work activities including the development and implementation of a return to work program. Any concerns associated with a claim should be referred to the relevant supervisor, who will endeavour to resolve these concerns or, where necessary, refer them to the insurer.

Day-to-Day Management

The person who has day-to-day responsibility for injury management is:

Name	
Position	
Telephone	

Return to Work Programs – Important Information for Employers

The Workers Compensation Injury Management Code of Practice came into effect on 14 November 2005 and is based on the principle that, whenever it is medically appropriate, an injured worker will remain in, or return to, work. A Return to Work (RTW) program is defined as a formal program developed to assist an injured worker to remain at or return to suitable work.

As an employer, you must establish a RTW program in the following circumstances:

- The injured worker's treating medical practitioner signs a medical certificate indicating that the injured worker has partial capacity to return to work; or
- The injured worker's treating medical practitioner advises you in writing that a RTW program is required

In most circumstances, you will be able to establish and implement the RTW program with your injured worker. QBE can provide support and information about RTW strategies or if required complete the program on your behalf.

In the QBE Injury Management Handbook we have enclosed a copy of QBE's RTW template, incorporating the information required to comply with current workers' compensation legislation.

General Guidelines For Developing a RTW Program

Establishment

- The injured worker must be given an opportunity to participate in the establishment of a RTW program. Providing the injured worker with an existing or standard RTW program is not sufficient.
- Reasonable steps need to be taken to ensure the injured worker agrees with the content of the RTW program and have them indicate this in writing (for example, have them sign the bottom of the RTW program)
- Documentation of the RTW program must comply with current workers compensation legislation (as per the attached QBE template).

Modification

- Circumstances will arise in which you may be required to update or modify the RTW program (for example, changes to the return to work goal or changes to the injured workers capacity for work).
- Ensure the injured worker agrees with any modifications made to the original RTW program.

Implementation

- Ensure the injured worker and the worker's treating medical practitioner are given a copy of the RTW program, including any modified versions.
- Review the program regularly and ensure that the actions listed in the RTW program are completed in a timely manner.

Like To know More?

Should you require any assistance with the development of the RTW program, please contact your QBE Case Manager.

QBE INSURANCE (AUSTRALIA) LIMITED
ABN 78 003 191 035
GPO Box T1750, Perth 6845
Telephone: (08) 9213 6100
Facsimile: (08) 9213 6199

Return to Work Program

Worker Details			
Name		Claim Number	
Phone Number (Work)		(Home)	

Employer Details			
Business Name		Contact Person	
Phone Number		Fax Number	

Doctor Details			
Doctor		Practice	
Phone Number		Fax Number	

Insurer			
Insurer	**QBE Insurance (Australia) Limited**	Case Manager	
Phone Number		Fax Number	

Treatment Provider			
Provider		Practice	
Phone Number		Fax Number	

Rehabilitation Provider			
Provider		Consultant	
Phone Number		Fax Number	

Program Details			
Return to Work Goal		Date of Medical Review	
Diagnosis			
Working Restriction on Current Medical Certificate			

List of Suitable Duties	Physical Demand

Program Details (continued)

Actions to be completed to enable Injured Worker to return to work

Action	Person Responsible	Review Date

Comments

Start Date		Review Date	

Return to Work Schedule

Week	Monday	Tuesday	Wednesday	Thursday	Friday	Total

Agreement by all parties involved in the development of this plan

Doctor's Signature	X	Date	
Worker's Signature	X	Date	
Employer's Signature	X	Date	
Name and position of person signing on behalf of emloyer			

QBE Insurance (Australia) Limited
ABN 78 003 191 035

GPO Box T1750
Perth 6845
Telephone: (08) 9213 6100
Facsimile: (08) 9213 6199

Employer's Report of Injury Western Australia

Policy No.		Risk No.		Cost Centre Code	

This form is to be completed by the Employer immediately after the occurrence and should be accompanied by the employee's Claim for Compensation and First Medical Certificate. Please read carefully the explanation on page three of this form regarding weekly compensation calculation. To ensure early refund of compensation this area must be completed.

Employer Details

Business Name					
Employer's ABN					
Address					
		State		Postcode	
Postal Address					
		State		Postcode	
Telephone	( )	Facsimile	( )	Email	
Nature of Business					
Number of employees engaged in the business		Total weekly payroll	$		

Injured Person Details

Surname	Given Names	Date of Birth
		/ /
Address		
	State	Postcode
Industry in which employed	Occupation	Date first employed
		/ /

What occupation was the worker engaged in at the time of the accident?

Was the worker employed: (a) Directly ☐ If directly emloyed: (i) Full-time ☐ (ii) Part-time ☐ (iii) Casual ☐

(b) As a contractor or subcontractor ☐ (c) By a contractor or subcontractor ☐

(d) Under a temporary visa ☐ Type of visa, e.g. 457

If in your direct employ, for years | Please indicate whether the worker has paid employment with another employer Yes ☐ No ☐

Is the injured worker: Right-handed? ☐ Left-handed? ☐

Previous claims with all employers (for same injured person). Give details.

Married or Single	Number of dependent children under 15 years	Number of days worked per week	Hours worked per week	Usual days off during week	Meal breaks between hours off	Number of hours worked each day	Is board and lodgings provided in addition to weekly wages?	Did the worker continue to work after the accident?	Length of time worked on day when injury occurred

Injury Details

Day of week		Date	/ /	Time	a.m. p.m.
Exact place or location where injury was sustained					
Did injured person give notice of injury?	Yes ☐	To whom was it given?			
	No ☐	If "No", why?			
When was it given?	a.m. p.m.	on		Verbally ☐	In writing ☐

Name of witnesses to the accident, persons in the vicinity or aware of the accident (witness statement(s) to be attached if obtained).

Give full details of how injury was sustained.

What is the nature of the injury?

If injury was caused by any person(s) not in your employ give full names and addresses of those concerned and the name and address of their employer.

Has worker discontinued duties?	Yes ☐ No ☐	If "Yes", Date	/ /	Time	a.m. p.m.
Has worker returned to full work duties?	Yes ☐ No ☐	If "Yes", Date	/ /	Time	a.m. p.m.
What is the estimated time of absence from work?					

Is compensation being claimed from any other source? Yes ☐ No ☐

If "Yes", please specify.

Injury Details (continued)

Supplementary remarks.

After reading carefully the explanatory notes below please complete the schedule

Weekly compensation rates are based on the 'weekly earnings' as defined in the *Workers Compensation and Injury Management Act 1981* (as amended).

Award Workers

If a worker is paid pursuant to an Industrial Agreement, Industrial Award, Certified Agreement, Australian Workplace Agreement or Enterprise Bargaining Agreement, the first 13 weeks of compensation shall be paid on the basis of the average weekly earnings for the 13 working weeks immediately prior to the date of the incapacity, and thereafter at the worker's basic award rate, plus any regular over award payment and any allowances paid on a regular basis as part of the worker's earnings and related to the number and pattern of hours worked. The maximum weekly compensation rate payable is prescribed by WorkCover WA.

Non Award Workers

If a worker is not paid pursuant to an award as noted above, the first 13 weeks of compensation shall be paid on the basis of the average weekly earnings for the 52 working weeks immediately prior to the date of the injury, and thereafter at the amount which is 85% of the 52 weeks' average. If the worker has not been employed for 52 weeks prior to the injury, please indicate number of weeks worked and total earnings.

Casual and Seasonal Workers

Please indicate number of weeks worked and total earnings.

Schedule – Please complete Section A or B

and provide a PRINTED WAGE SUMMARY indicating the total gross earnings for the relevant period prior to the date of injury.

A – Award Workers

Name of Award or Agreement under which Worker is paid						
Worker's Job Classification under that Award						
Base GROSS Award Weekly Rate of Pay and hours (not including overtime, bonuses or allowances)					$ (per week)	
					(hours per week)	
Type and amount of regular over award payment, bonus or allowance.	Type					
	Amount per week	$	$	$	$	$
Total GROSS earnings for the 13 weeks immediately prior to the date of incapacity					$	
Important: If the worker did not work for part of the 13 weeks, e.g. due to sick or annual leave, please disregard that period and state the number of weeks worked.					Total No. of weeks:	

B – Non Award Workers

Total GROSS earnings for the 52 weeks immediately prior to the date of injury	$	
If the worker has been employed by you for less than one year state the number of weeks employed by you		
Seasonal Workers		
Total GROSS earnings in past 12 months whilst employed with you	$	
If employed for less than 52 weeks the number of weeks employed by you		

Declaration

If payment is recommended please sign this form. If not, please sign and attach a statement providing reasons.

Having made an independent investigation into this claim, I certify that the above particulars are correct, and recommend payment of compensation.

Employer's Signature **X** Date / /

Name and position of signee

Name of Rehabilitation contact

No compensation is to be paid until authority from QBE has been obtained.

Important Information for Employers

1. Three day time limit

You have a statutory obligation to lodge the Worker's Claim form and First Medical Certificate, with QBE within three days of you receiving the Worker's Claim form and First Medical Certificate.

Failure to lodge the forms with QBE within three working days of claim notification can result in penalties pursuant to the Workers Compensation & Injury Management Act 1981.

2. Completing and sending in this form

Please complete every section of this form. Do not forget to provide the worker's earnings for either 13 weeks or 52 weeks prior to the injury depending on whether he/she is employed under an Award or not.

Please attach the Worker's Claim form and the First Medical Certificate to this form or QBE will be unable to process the claim.

Please send this form to QBE, GPO Box T1750, Perth 6845.

3. Payment of weekly benefits and medical accounts

Under no circumstances should you pay either weekly benefits or medical accounts in respect of a worker's claim unless authorised by QBE.

All medical accounts must be forwarded directly to QBE for consideration and payment. QBE will only reimburse accounts at the authorised Workcover rate which can be less than that charged in the account. Therefore, both employers and workers should avoid direct payment.

4. Rehabilitation

Pursuant to WorkCover requirements, if the treating medical practitioner has indicated that the worker will be off work for three days or more, or is unable to return to normal duties, you should complete the "Details to be Provided to Medical Practitioner" section on the Worker's Claim form and fax it to the treating medical practitioner within two working days.

Please ensure that you provide QBE with the name of the person responsible for rehabilitation in your company.

5. General Enquiries

If you have any concerns or queries about a worker's claim or completing this form please call the Workers Compensation Department of QBE Insurance on **(08) 9213 6100**.

QBE

Workers' Compensation Claim Form

Workers – tear off and keep this section for your information

QBE Insurance (Australia) Limited
ABN 78 003 191 035

GPO Box T1750, Perth 6845
Telephone : (08) 9213 6100
Facsimile : (08) 9213 6199

Who can make a claim?

You are entitled to make a claim if you sustain an ***injury in the course of your employment*** **and are defined by law as a *worker***. The legal definition of a ***worker*** includes full-time, part-time, casual, seasonal, piece and commission workers. Working directors, contractors and sub-contractors may also be defined as workers depending on their working arrangements.

How to claim:

Seek **first aid** and **report** the injury to your employer

↓

See a doctor of your choice as soon as possible and get a medical certificate. This is known as a *First Medical Certificate* in the workers' compensation system.

↓

Fill out the inside pages of **this form** and give it **and** your *First Medical Certificate* to your employer.

↓

Your employer must complete their part of the claim form and give it together with the *First Medical Certificate* to their insurer within **3 working days** of receiving the claim form.

↓

The insurer has **14 days** to assess the claim and can:

Accept the claim	Dispute the claim	Pend the claim
↓	↓	↓
Your workers' compensation entitlements commence	No entitlements are made – you can dispute this decision	No entitlements are made – the insurer needs more time to make a decision

What happens if you don't agree with the insurer's decision?

Your employer's insurer has an internal dispute resolution process. You can approach the insurer to re-examine their decision.

In addition, the Dispute Resolution Directorate is an independent body that hears and determines disputes that may occur within the workers' compensation system.

To find out more about lodging an application with the Directorate or for general information about worker's compensation and injury management contact **WorkCover WA's Advisory Services on 1300 794 744.**

How to make a claim with self-insurers

Some employers have been approved by WorkCover WA as self-insurers. This means that the employer covers the cost of its workers' compensation claims.

The process for making a workers' compensation claim is the same. However your **employer has 17 days** to assess your claim once they receive your completed claim form and *First Medical Certificate*.

You can ask your employer if they are a self-insurer. A list of self-insurers is available on the WorkCover WA website at www.workcover.wa.gov.au under Service Providers.

What happens when my claim is pended?

An insurer can pend your claim if they need more time or more information to make a decision. They may contact you during this time for more information about your claim.

While your claim is being assessed, consider using any accrued leave (sick leave or annual leave) to provide you with interim financial support. If your claim is accepted, any leave you have used will be reinstated by your employer.

If a decision has not been made within **17 days** of you lodging your claim form and *First Medical Certificate* with your employer, you can apply to WorkCover WA for **interim compensation payments.** Contact Advisory Services on 1300 794 744 for more information.

WorkCover WA is the government agency responsible for overseeing the *Workers' Compensation and Injury Management Act 1981.*

What does workers' compensation cover?

Once your claim is accepted you become entitled to workers' compensation payments. These may include:

- **wages** that should be paid on your normal pay day for any time that your doctor has certified you unfit for work
- **medical expenses** for hospital, medical and allied (eg physiotherapy) health treatment referred by your doctor and approved by the insurer. Your medical expenses are covered only up to a workers' compensation rate which is set by WorkCover WA. Be sure to check that your doctor charges this rate otherwise you may be left with a gap payment
- **rehabilitation expenses** to cover the cost of engaging an **approved workplace rehabilitation provider** to help your return to work
- **travel and accommodation** expenses in certain situations.

Contact WorkCover WA for publications about your rights, responsibilities and entitlements.

Wages, medical and rehabilitation payments are limited and subject to maximum amounts. You can call our Advisory Services staff on 1300 794 744 or visit www.workcover.wa.gov.au/Workers for further information.

While your claim is being assessed, you can ask your employer to pay you sick leave or annual leave you have already accrued. If your claim is accepted, you will receive your workers' compensation entitlements and your employer will reinstate your leave. **Remember you must have a medical certificate to cover any time you are away from work.**

Know and understand your rights and responsibilities

You:

- have the right to **choose your own treating doctor** and **workplace rehabilitation provider**
- have the right to **claim lost wages from other jobs** if you have another job/s your injury prevents you doing
- have the responsibility to **attend certain medical appointments** at the request of your employer
- have the responsibility to fully participate in your **return to work program** once developed.

Your employer:

- has the right to **request a medical review** via your insurer before or after a claim has been accepted
- has the **right to discuss your return to work** with the treating doctor
- has the responsibility to have an **injury management system in place** and implement a **return to work program** when a doctor declares you fit for work in any capacity
- has the responsibility to keep **your original position available** for 12 months following a claim.

Together:

- you have the responsibility to fully participate with your treating doctor in developing an appropriate **return to work program.**

Disclosure of Personal Information (consent authority)

Your employer's insurance company needs to collect, use and disclose personal information to assess, investigate and otherwise deal with your claim. **If you do not provide the information requested, this may affect the insurer's ability to assess your claim. This may cause significant delays in the claims process.**

By signing the *consent authority* on the Claim Form, you agree to the insurer:

a. collecting and using your personal information for the purpose of assessing, investigation and otherwise dealing with your current claim or any future claims.

b. disclosing personal information (on a confidential basis) to and collecting personal information from:

   - your employer, the insurer's entities, its investigators, auditors, medical service providers or any other party providing services to the insurer or any agent of these
   - other insurers, insurance intermediaries, government regulators or insurance reference bureau
   - lawyers and law enforcement agencies.

Workers' Compensation Claim Form

Insurer please complete

Insurer name
Claim number
ANZSIC Code
Policy number
WorkCover number
Has employer contacted medical practitioner? ☐ Y ☐ N

Estimated time off work:
- ☐ less than one day
- ☐ 1-4 work days (inclusive)
- ☐ 5-9 work days (inclusive)
- ☐ 10-20 work days (inclusive)
- ☐ more than 20 work days
- ☐ fatality

Date form received from employer

DATE STAMP

ASCO (office use only)

Employer please complete

Name of policy holder/employer: _____
Trading as (if different to above): _____
Address: _____ Postcode: _____
Contact person name: _____ Phone No: _____ Email: _____
Address of injured worker's usual workplace or base: _____ Postcode: _____
Major activity of workplace (eg sheep farming, plumbing): _____
Date employer received the completed claim form from the injured worker: _____
Date employer received First Medical Certificate from the injured worker: _____
Date employer sent the claim form and medical certificate/s to insurer: _____

Worker please complete

Surname:
Other names:
Address:
Suburb/City/Town: _____ Postcode: _____
Email:
Daytime contact phone no:
Occupation (eg first class welder)
Main tasks/duties performed (eg welding of high pressure steam pipes)

D.O.B. ☐ Male ☐ Female
Preferred language (if not English)

At the time of the injury I was working as a:
- ☐ direct employee
- ☐ sub contractor
- ☐ working director
- ☐ visa worker
- ☐ contractor
- ☐ other
- ☐ employee of contractor

If other, please specify:

☐ full time (F) ☐ part time (P) ☐ permanent (P) ☐ temporary (T) ☐ casual (C)

Other Employment

If more than one employer, please attach details on separate sheet

Do you have any other job? ☐ Y ☐ N If yes, please give details:
Employer name: _____ Phone no: _____ Hours per week: _____

Occurrence details

Attach separate sheet if more space is required

Day of occurrence: eg Monday | Date of occurrence: | Time of occurrence: ☐ AM ☐ PM

At what address did the occurrence happen?

Did you have to stop working? ☐ Y ☐ N If so when? Date: Time: ☐ AM ☐ PM

Were you:
- ☐ working – at your normal workplace
- ☐ on work break – at normal workplace
- ☐ working – away from normal workplace
- ☐ on work break – away from normal workplace
- ☐ working – road traffic accident commuting/journey
- ☐ other duty status

Describe the occurrence. Include:
(i) What action was involved (ie fall, struck by object)
(ii) What object/machine/substance was involved (ie fumes, door frame)
(iii) The most serious injury or disease caused (ie fracture, burn, abrasion)
(iv) The bodily location of the injury or disease (ie upper arm, eye)

WorkCover WA Staff Only
Mechanism
Agency
Nature
Bodily location

Worker please complete

Occurrence report – Describe how it happened

Attach separate sheet if more space is required

Where did the occurrence happen? (ie store room, machinery shop)

What were you doing at the time of the occurrence?

What were the normal working hours for that day? Starting time: ☐ AM ☐ PM | Finish time: ☐ AM ☐ PM

When did you first report the occurrence? Date: Time: ☐ AM ☐ PM

Who did you report the occurrence to?
Name: Position: Phone No:

If you didn't report the occurrence immediately, please state the reason if any:

Please provide the name and daytime contact phone number of witnesses of the occurrence:
1. Name: Phone No:
2. Name: Phone No:

Medical help/history – this occurrence

Attach separate sheet if more space is required

When did you first seek medical attention? Date: Time: ☐ AM ☐ PM
If not immediately, please state the reason:

Was the part of the body affected by this occurrence healthy before this occurrence? ☐ Y ☐ N
If not, please give details:

Is the present injury completely related to this occurrence? ☐ Y ☐ N If not, please give details:

Please give details of any similar injury prior to this occurrence:

Name and contact details of your usual medical practitioner and any health provider who has treated you for a similar injury:
Name: Address: Phone no:

Other/Previous claims

Attach separate sheet if more space is required

Are you claiming compensation from any other source? ☐ Y ☐ N If yes, from whom?

Have you had any similar or related workers' compensation claims? ☐ Y ☐ N If yes, please give details:

Name of Employer: Address:
Name of insurer (if known): Type of injury or disease:

Worker's declaration

I solemnly and sincerely declare that each and every answer above and the particulars contained herein or annexed hereto relating to myself and the occurrence are true both in substance and in fact to the best of my knowledge and belief. I take notice that, under the provisions of section 59(2) of the *Workers' Compensation and Injury Management Act 1981*, I am required to notify my employer in writing within 7 days if I commence work with another employer after making a claim, or while receiving weekly payments of workers' compensation.

Dated this day of : Year:

Signature of worker Signature of witness

Consent authority (to be signed at the option of the worker) I authorise any doctor who treats me (whether named in this certificate or not) to discuss my medical condition, in relation to my claim for workers' compensation and return to work options, with my employer and with their insurer.

Dated this day of : Year:

Signature of worker Signature of witness

Consent authority – to be signed at the option of the worker

I consent to my employer's insurer and its appointed service providers collecting personal information, inclusive of sensitive information such as medical information about me and using it for the purpose of assessing and managing my workers' compensation claim, including determining liability and whether my claim is true. This consent extends to my employer's insurer disclosing my personal information, inclusive of sensitive information, to other insurers, medical practitioners, rehabilitation providers, investigators, legal practitioners and other experts or consultants for the purpose of assessing and managing my claim. My personal information, inclusive of sensitive information, may also be disclosed as required or permitted by law. I also consent to my employer's insurer disclosing my personal details to WorkCover WA which is authorised to use this information to fulfil its functions and obligations under the *Workers' Compensation and Injury Management Act 1981*. I have read all the information on this form regarding the consent authority and I consent to the Insurer dealing with my personal information in the manner described.

Signed Witness signature

Print your name Witness print name

Date Date

IMPORTANT: FAILURE TO PROVIDE YOUR SIGNATURE ON EITHER THE DECLARATION OR THE CONSENT AUTHORITIES MAY DELAY A DECISION BY THE INSURER ON YOUR CLAIM

Checklist and handy hints

For the Worker

- ☐ Complete the form with a ballpoint pen.
- ☐ If you need help completing the form, you can get your employer, a friend or family member to help you or you can call WorkCover WA on 1300 794 744. If required, an interpreter can also be arranged by WorkCover WA free of charge.
- ☐ The claim form is printed on carbonised paper which produces an exact copy on the sheet below it. Make sure you write on the centre sheets only and press firmly.
- ☐ Provide **all** the information requested. Give your full name, postal and email address and daytime contact phone number in case you need to be contacted.
- ☐ It may be helpful to attach a separate sheet to your claim form **if more space is needed** to provide information about your injury, how it happened and your medical history.
- ☐ Read and sign the ***worker's declaration*** and the ***consent authority (optional).***
- ☐ Attach the *First Medical Certificate* you received from your doctor to this claim form (your claim cannot be processed until both your claim form and *First Medical Certificate* are received).
- ☐ Keep records! Take a photocopy of your claim form and keep a record of the date you gave the claim form and medical certificate to your employer.
- ☐ Tear off the information section of this form and keep for your future reference.

For the Employer

- ☐ **Tear off the information section of this form and give it to the injured worker.**
- ☐ Make sure the worker has completed all sections of the claim form. If they have difficulty completing it, let them know that they can seek help from you, or a family member or friend.
- ☐ Make sure you complete the employer details section.
- ☐ Review the *First Medical Certificate*. Has the doctor indicated that the worker has **capacity to work** in either their pre-injury job or in alternative duties? If so, you are required by law to **develop a return to work program.** Visit the WorkCover WA website www.workcover.wa.gov.au for further information and templates or contact your insurer for assistance.
- ☐ If the doctor has indicated that the worker will be off work for more than three days or can't return to normal duties, they will be expecting you to contact them.
- ☐ Keep records! Develop a case file, photocopy all relevant paperwork and keep it in a safe and private location and date all correspondence.
- ☐ Forward this form to your insurer within **three working days** of receiving it. Make sure you attach:
  - the worker's *First Medical Certificate* and any subsequent medical certificates
  - medical accounts (if any)
  - any other reports your insurer asks you to complete.
- ☐ If an injury is likely to prevent an employee from working for **10 consecutive days**, you **must also notify WorkSafe** on (08) 9327 8800. A list of reportable injuries and diseases can be found at: www.commerce.wa.gov.au/WorkSafe/ There are also reporting requirements for **all injuries in the mining sector.** Visit www.dmp.wa.gov.au for further details.

Further information and assistance

WorkCover WA is the government agency responsible for overseeing the *Workers' Compensation and Injury Management Act 1981* (the Act) in Western Australia.

The role of WorkCover WA is to monitor compliance with the Act, inform and educate parties on all aspects of the workers' compensation and injury management system and provide an independent dispute resolution service.

If you would like further information about workers' compensation and injury management or information about seminars for injured workers contact:

WorkCover WA
2 Bedbrook Place
Shenton Park WA 6008

Advisory Services 1300 794 744
TTY (hearing impaired) (08) 9388 5537

www.workcover.wa.gov.au

An interpreter service is available by arrangement with WorkCover WA.

Injury Management

Injury management is about managing workers' injuries in a manner that is **directed at enabling injured workers to return to work.**

Your employer should have a **written description of an injury management system** in your workplace and this should be made available to you if you ask for it.

You should be involved with decisions regarding your return to work.

It is important for you to:

- keep in touch with your employer, your doctor and other treatment providers
- submit medical certificates to your employer as soon as possible and on a regular basis to help keep your employer informed of your medical condition and level of fitness for work.

If your treating medical practitioner finds that you are partially fit to return to work in some capacity, a written return to work program will be established by your employer.

Workers should fully participate with their employer and medical practitioner in developing an appropriate return to work program. This will help develop a supportive environment that has the commitment of all parties to a successful return to work process. You have the responsibility to actively participate in your return to work program once developed.

Make sure you have a say in determining your future at work by being involved in discussions that affect you.

Publications for workers available from WorkCover WA:

- *Workers' Compensation and Injury Management: Important Information for Workers*
- *Understanding Workers' Compensation Entitlements*
- *A Guide to Resolving Disputes*
- *When do I need an Approved Medical Specialist? Information for Workers.*

WorkCover WA also has a range of DVDs and fact sheets available to assist you to manage your claim.

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