CONCILIATION SERVICE
2 Bedbrook Place
Shenton Park WA 6008
Ph 08 9388 5555
Fax 08 9388 5690
www.workcover.wa.gov.au

CONCILIATION SERVICE

APPLICATION FOR CONCILIATION

Form 100

Office use only

Case number | Related case number(s)

Section A - Applicant name
(party who is making application, e.g. worker's name)

Section B – Respondent name
(who is application against, e.g. employer name)

Note: Form 105 to be completed if there are multiple respondents

Section C – Lodged by *(please tick relevant box)*

- ☐ Worker
- ☐ Worker Representative
- ☐ Employer
- ☐ Employer representative
- ☐ Insurer
- ☐ Insurer Representative
- ☐ Dependant
- ☐ Service provider
- ☐ Other

Section D – Signature of applicant (this form must be signed or it will be rejected)

I confirm I am ready to proceed with this dispute and I have attached documents supporting the application.

Name | Signature | Date

Section E – Injury details

Date of injury | Date claim made on employer | Claim number

Nature and circumstances of injury *(provide a brief description of current injury)*

Section F – Worker's details

Title | Given names | Surname

Occupation | Date of birth | ☐ Male ☐ Female

Postal address

City/suburb | State | Postcode

Preferred method of written contact *(complete only if applicant)* ☐ Mail ☐ Email ☐ Fax

Daytime phone number | Mobile | Fax

Email address

Interpreter required? ☐ Yes ☐ No | If so, Language/dialect

Note: All sections to be completed by applicant or their representative, to the best of their knowledge, unless indicated.

Section G – Worker's representative details *(if represented by a legal practitioner or registered agent)*

Company name

Contact person | Reference number

Phone number | Mobile | Fax

Email address

Section H – Employer details

Employer name

Postal address

City/suburb | State | Postcode

Contact person

Preferred method of written contact
(complete only if applicant)
☐ Mail ☐ Email ☐ Fax

Phone number | Mobile | Fax

Email address

Interpreter required? ☐ Yes ☐ No
If so, Language/dialect

Section I – Employer's representative details *(if represented by a legal practitioner or registered agent)*

Company name

Contact person | Reference number

Phone number | Mobile | Fax

Email address

Section J – Insurer/self insurer details

Company name

Contact person | Reference number

Phone number | Mobile | Fax

Email address

Section K - Insurer/self insurer representative details *(if represented by a legal practitioner or registered agent)*

Company name

Contact person | Reference number

Phone number | Mobile | Fax

Email address

Section L – Other party details *(if any other parties are involved in the dispute – may not apply)*

Category: ☐ Allied health provider ☐ Service provider ☐ Dependant ☐ Other

Company

Contact person

Postal address

City/suburb | State | Postcode

Preferred method of written contact *(complete only if applicant)* ☐ Mail ☐ Email ☐ Fax

Daytime phone number | Mobile | Fax

Email address

Interpreter required? ☐ Yes ☐ No | If so, Language/dialect

Section M – Other party representative details *(if represented by a legal practitioner or registered agent)*

Representative

Contact person | Reference number

Phone number | Mobile | Fax

Email address

Section N – Outline each matter in dispute

Category of the dispute, i.e. dependency, determination of liability, settlement, statutory allowances, weekly payments

Section O – Outcomes sought

Indicate the outcome(s) sought based on the ground(s) of dispute detailed above, i.e. details of statutory expenses, details of weekly payments including reductions/discontinuance sought

Section P – Details of attempts to resolve the dispute

The applicant must indicate what attempts have been made to resolve the dispute or application may be rejected.

Section Q – Supporting documents lodged

Send completed form to

Conciliation Service
WorkCover WA
2 Bedbrook Place
SHENTON PARK WA 6008
or
Fax: (08) 9388 5690

For further information :

Advisory

Phone (08) 9388 5555
or
1300 794 744