Claimant Name | Date of Injury / / | Claim No.

WorkCover NEW SOUTH WALES

WORKCOVER AUTHORITY OF NEW SOUTH WALES

WORKER'S INJURY CLAIM FORM

FOR HELP COMPLETING THIS FORM OR FOR MORE INFORMATION CONTACT:

- Your employer or the return to work coordinator at your workplace
- Your employer's WorkCover Agent – to find out who the Agent is request the details from your employer, check the If you are injured poster at your workplace or call the WorkCover Information Centre on 13 10 50 – cost of a local call
- Your union

AS THE WORKER YOU NEED TO:

✓ Notify your employer as soon as possible that you've been injured at work and complete the injury register at your workplace.

✓ See your nominated treating doctor who may provide a *WorkCover Medical Certificate* and if so, give the original copy of the certificate to your employer.

✓ Complete a claim form if requested by your employer or their Agent.

✓ Read the statement on the back of this form that explains how your personal and health information will be collected and used.

✓ Answer all of the questions on this form. It is important to advise the Agent immediately of any changes of circumstances that impacts on the information provided in this form.

✓ Sign the authority to release medical information and worker's declaration on page 3 of this form. The form cannot be accepted without your signature.

✓ Keep a copy of all documents for your records (including a copy of this form).

✓ Give this form (when completed) to your employer as soon as possible after being injured. If you or your representative have difficulty giving this claim form to your employer, or your employer refuses to take receipt of the claim form, you can send it directly to the Agent or contact WorkCover on 13 10 50.

✓ Contact the WorkCover Claims Branch on 1800 221 960 to request an additional form if you are a volunteer with a property damage claim.

GETTING BACK TO WORK

- **Talk to your nominated treating doctor about what parts of your work you can do and any medical restrictions that should apply. You can also encourage your nominated treating doctor to talk to your employer about any suitable duties that may be available.**
- **Talk with your employer or return to work co-ordinator about developing a return to work plan. A return to work plan outlines the actions to be undertaken to assist you to return to work.**
- **Talk to the Agent about what support is available to help you return to work and overcome your injury as quickly as possible.**
- **Cooperate and comply with your return to work plan and the injury management plan developed for you by your employer's Agent. An injury management plan is developed to coordinate and manage any treatment / rehabilitation / retraining required to assist you to return to work.**

YOUR EMPLOYER'S RESPONSIBILITIES:

- Your employer must send your completed claim form and any WorkCover Medical Certificates to the Agent within 7 days after receiving them from you.
- Pay you weekly payments if your claim is accepted and you have an entitlement.
- Offer suitable employment if practical and work with you to develop a return to work plan once your doctor has determined if any restrictions are necessary.

Please note that there are penalties for providing false or misleading information in relation to this claim.

Your employer's Agent will write to you and advise you if your claim is accepted or if further information is required.

A decision to accept or reject provisional liability for your claim will be made within 7 days of the Agent receiving notification of your injury. The acceptance of provisional liability is not an admission of full liability for your claim, but allows an Agent to make early payments to you for wages and medical expenses.

To find out more about making a claim and what support is available to help you return to work, talk to the Agent, contact your union or the WorkCover Information Centre – 13 10 50 (cost of a local call). You may also refer to the brochures *Information for Injured Workers, Suitable Duties: Information for Employers and Injured Workers, Your Recovery and Return to Work After a Workplace Injury and WorkCover Guidelines for Claiming Compensation Benefits* or visit the website at www.workcover.nsw.gov.au.

Should you experience difficulty and require assistance please contact the Claims Assistance Service on 13 10 50.

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

New South Wales Government

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)

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

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 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

COLLECTION OF PERSONAL AND HEALTH INFORMATION TO MANAGE YOUR CLAIM

In processing your claim, the WorkCover Authority of New South Wales ("WorkCover") and any Agent acting on behalf of WorkCover in relation to your claim may collect personal and health information about you.

WorkCover is a statutory body established under the Workplace Injury Management and Workers Compensation Act 1998. WorkCover, acting for the Nominal Insurer, has appointed Agents to act on its behalf in managing workers' compensation policies and claims for compensation.

Personal and health information is collected about you on this form and may also be collected during the processing, assessing and management of your claim. It may be collected from your current, previous and future employers, other government agencies, credit reporting agencies, health service providers and other persons who can provide information relevant to the claim.

Personal and health information about you may also be collected by solicitors, private investigators, loss adjusters and other service providers acting on behalf of WorkCover or its Agents.

Personal and health information is collected for the purposes of enabling WorkCover or its Agents to process, assess and manage your claim and to verify any evidence you may submit in support of a claim. The information may also be used for one or more purposes listed in section 243 of the Workplace Injury Management and Workers Compensation Act 1998 ("1998 Act"), for the purposes of legal proceedings arising under the 1998 Act or the Workers Compensation Act 1987, to assist with your rehabilitation and return to work and to assist WorkCover and its Agents to better manage claims generally.

For the purposes of processing, assessing and managing your claim, WorkCover and its Agents may disclose personal and health information about you to each other and to the following types of organisations:

- Employees, contractors and agents of WorkCover and WorkCover's Agents.
- Your employers.
- Solicitors, medical practitioners and other health service providers, private investigators, loss adjusters and other service providers acting on behalf of WorkCover or its Agent in relation to the claim.
- The Workers Compensation Commission and Approved Medical Specialists.
- A court or tribunal in the course of proceedings under any of the Acts administered by WorkCover.
- Any other person, organisation or government agency authorised by you, or by law, to obtain the information.

Collection of this information may be required by the Workplace Injury Management and Workers Compensation Act 1998 and the Workers Compensation Act 1987. If you do not provide any part or all of this information, your claim may not be accepted or processed.

All information collected in this form will be held by WorkCover, or by the Agent managing your claim. If you do not know the contact details for the Agent managing your claim please refer to the WorkCover website (**www.workcover.nsw.gov.au**) or ring the WorkCover Information Centre on 13 10 50.

You may request access to personal and health information about you collected by WorkCover or its Agents, by contacting the Agent directly. You may also request the correction of any errors in the personal or health information held by WorkCover or its Agents.

* If your injury employer is a licensed self-insurer, where you read "WorkCover" and "Agent" also read "self-insurer" and "approved agent of a self-insurer".

* If your injury employer has a policy with a licensed specialised insurer, where you read "WorkCover" and "Agent" also read "specialised insurer" and "approved agent of a specialised insurer".