



## WORKER REPORT FORM

- Notice of Work-related Injury - Green Copy
- Claim for Compensation - Orange Copy
- Worker's Copy - Blue Copy

### TO THE WORKER

Do you wish to claim for expenses eg, doctor's bills or lost wages?

**YES**

Complete the whole form and give it to your employer **as soon as possible** along with a medical certificate supporting your claim and any accounts you may have. Keep the worker's copy in a **safe place** for your own record.

**NO**

Complete sections 1,2,4 and 9 of this form and give the green Notice of Work-related Injury to your employer **as soon as possible**. Keep the orange Claim for Compensation and blue Worker's Copy in a **safe place** should you need to make a claim at a later date.

If you need help filling in this form speak to:

- your supervisor
- your employer's workers compensation or occupational health and safety coordinator
- your health and safety representative
- your union representative
- the Service Centre at WorkCover (telephone 13 18 55). If you are unable to fill in the form because it is in English, staff from the Service Centre will arrange interpreting services. This interpreting service is free.
- If there is insufficient space provided for a response to any of the questions, please attach additional information, making sure it is signed and dated.

### TO THE EMPLOYER

If this notice is for an 'immediately notifiable work related injury' you must, if you have not already done so, notify your Local Regional Office of SafeWork SA by telephone 1800 777 209 or fax pursuant to Reg 6.6.2(1) of the Occupational Health, Safety and Welfare Regulations, 1995. SafeWork SA may also be contacted at [help@safework.sa.gov.au](mailto:help@safework.sa.gov.au)

#### ADDITIONAL NOTE FOR EMPLOYERS WITH A CLAIM AGENT

**Notices of work-related injury** (green page) must be forwarded to your workers compensation Claims Agent within five business days of receiving it unless:

- the disability does not, or is unlikely to, require medical treatment; *and*
- the disability is only temporary and not of a recurrent nature; *and*
- no time is lost other than the time required for treatment.

**Claims for Compensation** (orange page) must be forwarded (after completing Section 10) to your workers compensation Claims Agent within five business days of receipt together with an Employer Report Form.

**Failure to forward these forms may incur penalties of \$1000 and imposition of supplementary levies.**

**To lodge a claim over the phone call WorkCover EarlyClaim on 13 18 55.**

## NOTICE OF WORK-RELATED INJURY (GREEN COPY)

### 1 - ABOUT THE WORKER

Family name

Other names

Title Mr ☐ Mrs ☐ Ms ☐ Miss ☐

Former name (if changed since last claim)

Sex Male ☐ Female ☐

Date of birth (day/month/year)  /  /

Country of birth

Do you wish to identify as ☐ Aboriginal ☐ Torres St. Islander

You do not have to answer this question. This information will help WorkCover to improve services to Aboriginal and Torres Strait Islander people and will not affect your claim.

Residential address

Postcode

Postal address (if different from above)

Postcode

Daytime telephone

Mobile phone

Language spoken or read at home

Dialect

Interpreter required? Yes ☐ No ☐

Name and address of your employer at the time of injury/disease



Postcode

Is this employer your current employer? Yes ☐ No ☐

Was time lost from work due to injury/disease? Yes ☐ No ☐

What are your normal gross weekly earnings? \$

Do you regularly work overtime? Yes ☐ No ☐

Amount per week \$

Do you receive any other allowances?

Yes ☐ No ☐

What type?:  Amount per week:

Occupation eg, cook

### 2 - INJURY/DISEASE DETAILS

PLEASE BE AS SPECIFIC AS POSSIBLE.

What injury/disease did you suffer?  
eg, broken left lower leg, dermatitis of the hands.

What part of the body was affected?

eg, left upper arm, internal organs.

Name of certifying doctor (if applicable)

When did the injury/disease occur? (tick relevant box)

- 1 ☐ while working at usual workplace
- 2 ☐ traffic accident while working
- 3 ☐ while having a break
- 4 ☐ while travelling to or from work
- 5 ☐ while attending an approved course of study
- 6 ☐ while working elsewhere
- 7 ☐ other (please specify)

Exact location, address and postcode where the injury or disease occurred eg, loading bay - 100 Wright St, Adelaide 5000



When did your injury happen or when did you first notice the injury/disease?

Date  /  /

Time  am/pm

If you stopped work due to injury/disease - Date and time stopped work

Date  /  /

Time  am/pm

Names of any witnesses to your injury/disease



### 3 - MEDICAL AUTHORITY

Signing this authority will help your claim to be processed more quickly.

I give permission for my medical expert to provide WorkCover Corporation, my exempt employer or my employer's Claim Management Agent with information relating to my injury or condition.

I also give permission for any medical expert to receive x-rays, medical records or reports, relating to my claim (including copies) for the purpose of writing a report about my injury or condition.

A photocopy of this medical authority is as valid as the original.

Signature of the worker

Date

/ /

**4 - WHAT HAPPENED?**

Please give specific details about the events/equipment, which led to the injury or contributed to the disease.

**IMPORTANT:** Please read the examples on the back page before completing this section

What were you doing at the time?


What led to the injury or disease?


What exactly caused the injury or disease?

Give the name of any chemical, object, process or equipment involved


**5 - JOURNEY INFORMATION**

If the injury/disease happened in a traffic accident while working or while travelling to or from work complete the following

Did the police attend the accident? Yes ☐ No ☐

Police report no. (if known)

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**NOTE:** You may be asked to complete a vehicle accident report form.

**6 - OTHER CURRENT EMPLOYERS**

Do you have any other employment? Yes ☐ No ☐

If yes give details...

1 Name of the employer in full

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Address

Postcode

2 Name of the employer in full

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Address

Postcode

**7 - OTHER SIMILAR INJURIES OR DISEASES**

Have you suffered any similar injury or disease? (it need not be work-related or have occurred in SA) Yes ☐ No ☐

If yes give details...

1 Date Name of the employer (if applicable)

/ /	
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Nature of the injury or disease

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2 Date Name of the employer (if applicable)

/ /	
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Nature of the injury or disease

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3 Have you ever made a Worker's Compensation Claim, in this or any other name, in SA or elsewhere?

Yes ☐ No ☐

Details

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4 Have you ever had a Worker's Compensation Claim redeemed in SA? Yes ☐ No ☐

Details

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**8 - ELECTRONIC FUNDS TRANSFER (EFT) DETAILS**

Please provide your bank details to have any workers compensation benefits deposited directly into your bank account. CHEQUE PAYMENTS ARE NOT AVAILABLE

Bank name

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Branch address

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Bank BSB number

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Account number

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Account name

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Note: A remittance advice of any payment/s processed via EFT will be sent to you via post.

Please advise the claims agent (within 5 days) if any of the bank account details provided are changed.

**9 - DECLARATION**

I,

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declare that the information I have given on this form is correct to the best of my knowledge. I understand that it is an offence to give false or misleading information.

Signature

Date

	/ /
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If you have signed this form on behalf of the injured or diseased person (eg, if hospitalised) please give your name and address.

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Postcode

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**10 - EMPLOYER'S SECTION**

TO BE COMPLETED BY THE EMPLOYER

Employer's Reg No.

Location No.

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Date incident first reported to employer

/ /
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Date 'claim for compensation' form received by employer

/ /
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Name of person to whom notice was given

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Ph

Signature of employer

Date signed

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/ /
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## EXAMPLES OF QUESTION 4 - WHAT HAPPENED?

What were you doing at the time?		What led to the injury or disease?		What exactly caused the injury or disease?
servicing pasteurising equipment	▷	long term mechanical vibration of plant caused steam pipe on pasteuriser to fracture	▷	escaping steam from pipe burnt forearm
walked outside to front end loader	▷	slipped over in a puddle of water on driveway	▷	hitting my head on front end loader
machining wood on band saw	▷	band saw caught in knot in wood throwing wood out	▷	wood flying up and hitting head
using angle grinder	▷	cast iron chip flew from angle grinder	▷	foreign body entering unprotected eye
repeatedly lifting cartons of wine	▷	lifting	▷	heavy cartons of wine
washing dishes over a period of time	▷	longer term exposure to dish washing detergent	▷	contact with detergent

## KNOW YOUR RIGHTS

- To have your claim determined, wherever possible, within 10 business days of lodging this form with your WorkCover Medical Certificate attached.
- To be advised about the possibility of payment of interim benefits.
- To be paid weekly payments once your claim is accepted.
- To have medical and other expenses paid promptly eg, travel.
- To have an individual rehabilitation program or rehabilitation and return to work plan developed if you are incapacitated and unable to return quickly to work.
- To be meaningfully involved in all decisions regarding your rehabilitation program/plan.
- To have a current copy of your approved rehabilitation program/plan.
- To raise with the person managing your claim any dissatisfaction with the rehabilitation provider that has been allocated to you.
- To have a treating doctor/specialist of your choice.
- To obtain a second opinion from a specialist.
- To be provided with copies of all medical reports concerning your claim within seven days of the Claims Agent or Self-Insured employer receiving them.
- To have a representative present at any meeting or hearing about your claim (eg, union, employee advocate, solicitor).
- To have any personal information kept confidential.
- To apply to have most decisions reviewed by Worker's Compensation Tribunal eg, rate of pay.
- To have an interpreter at meetings and appointments.

## KNOW YOUR RESPONSIBILITIES

- To provide a WorkCover Medical Certificate to your employer to cover all time lost from work.
- To attend medical appointments reasonably made for you. Unless you have a valid reason your income maintenance could be discontinued for non-attendance.
- To actively participate in an established rehabilitation programme to return to work.
- To ensure that you do not provide any false or misleading information about a claim. (Note: It is an offence to provide false or misleading information about a claim)