

INJURED WORKER’S REPORT

About You

1 Surname

Mr/Mrs/Miss/Ms

2 First/Other Names

3 Address

Postcode:

4 Telephone No

W ()

H ()

5 Date of Birth

___/___/___

6 Sex

Male

Female

7 Where were you born?

Australia

Overseas

If ‘overseas’ print country of birth

Office use

8 Do you speak a language other than English at home?

No

Yes

If ‘yes’ print language spoken

Office use

About Your Condition

9 Date and time the injury or condition occurred, first noticed or identified

___/___/___

:

am/pm

10 Describe how the injury or condition occurred

(i) Give the details of what happened, how it happened and what was involved, e.g. knocked off ladder by tractor and tractor ran over legs; inhaling asbestos fibres when demolishing old buildings

Office use

Mech

Agency of Injury

B/dwn Agency of Injury

(ii) What was/were the most serious type(s) of injury or disease caused by this occurrence? e.g. burn; cut; fracture; hernia

Injury

(iii) What part of the body was most seriously affected by this occurrence? e.g. upper arm; left ankle; right eye; upper back

POB

You must attach a Workers Compensation Medical Certificate to this claim.

11 Where did your injury or disease occur?

Print town, suburb or locality

Postcode

ASGC

12 Date and time you stopped work

___/___/___

:

am/pm

13 Date and time you started work on the day or shift of the accident

___/___/___

:

am/pm

14 When did your injury or disease occur?

At work—working at normal workplace

At work—road traffic accident

At work—on authorised break

At work—working away from normal workplace

Away from work during recess period

Travelling to or from work

15 Is your injury or condition solely due to this occurrence?

No

Yes

16 Are there other causes of your condition?

No

Yes

17 Name of treating doctor

18 Name of treating hospital

Worker’s Medical Authority

NOTE: You do not have to complete this Authority. However, not doing so may mean delays to your claim being finalised.

To any medical practitioner or other person who has treated me, or the Registrar of any hospital at which I have received treatment.

I, employed by

authorise any medical practitioner or any other person who has treated me or the Registrar of any hospital at which I have received treatment to give my employer, or his insurer, information about myself specific to this claim for worker’s compensation. A photocopy of this authority is to be considered as valid as the original.

19 Your signature

20 Date Signed

___/___/___

Notification and Witnesses

21 Name of person notified

22 Date and time notified

___/___/___

:

am/pm

23 Your supervisor’s name

24 Name of any witnesses

25 Have you made any claims before?

No

Yes

If yes, give details below

Worker’s Certification

The Workers Rehabilitation and Compensation Act 1988 imposes heavy penalties for giving false or misleading information.

I declare that to the best of my knowledge and belief, all the information given in this form is true and correct in every particular.

26 Your signature

27 Date signed

___/___/___

28 Witness to signature

EMPLOYER’S REPORT

29 Employer’s legal name, i.e. Registered Company Name, State Government Department, Partnership, Sole Trader’s Name e.g. J Citizen Pty Ltd, Department of Education

30 Australian Business Number (ABN)

31 Employer’s address

Postcode:

32 Employer’s trading name or Division in State Government Department, e.g. J Citizen’s Laundromat, Primary Education

33 Employer’s major business activity at the injured worker’s workplace, e.g. dry cleaner, wholesale grocer, dental surgery

34 How many workers do you employ in Tasmania, not just this workplace?

head count:

Rehabilitation Details

35 Does the worker’s Medical Certificate indicate a need for rehabilitation?

No

Yes

36 Can suitable duties be provided?

No

Yes

37 What is the worker’s estimated time off work?

No lost time

Less than one day

1 day to 2 weeks

More than 2 weeks, less than 3 months

More than 3 months

Worker’s Employment Details

38 Normal weekly earnings (See front page for explanation)

\$

39 Ordinary time rate of pay per week (See front page for explanation)

\$

40 Average hours usually worked per week

(hrs)_____ (mins)_____

41 Average days usually worked per week

42 Describe the worker’s normal occupation

43 Department or section e.g. dispatch, warehouse, sales

Office use

Office use

44 Date the worker started in your employment

___/___/___

45 Is the worker a:

Direct employee

Contractor

On commission

Other

If ‘other’ give details below, e.g. in training program, police volunteer, fire fighting/fire prevention operations, etc

46 Claim lodgement date

___/___/___

47 Date of next payday following the date of claim lodgement

___/___/___

Employer Contact Information

Please give the name of someone who can be contacted for additional information about this claim

48 Contact Name

49 Contact Phone

()

Employer Certification

The Workers Rehabilitation and Compensation law imposes heavy penalties for giving false or misleading information

I am satisfied that the information given on this form is true and correct

I believe that further investigation into this claim is required

50 Employer representative’s signature

51 Date signed

___/___/___

52 Name of representative

53 Position

INSURER’S REPORT

Policy and Claim Details

54 Insurer name

Insurer Number

Office use

55 Policy Number

56 ANZSIC classification of policy

57 Claim number

58 Claim type

New

Re-opened

Aggravation

Recurrence

Other

If reopened, tick one below

If ‘other’ give details below:

59 Date of claim receipt by insurer (For self-insurers this date will be the same as shown in question 46)

___/___/___