

# WORKER'S INJURY CLAIM FORM

## FOR HELP COMPLETING THIS FORM OR FOR MORE INFORMATION CONTACT:

- Your employer or the nominated Return to Work Coordinator at your workplace
- Your employer's WorkSafe Victoria (WorkSafe) Agent - to find out who the Agent is check the *If you are injured* poster or call the WorkSafe Advisory Service: freecall 1800 136 089 or (03) 9641 1444
- WorkSafe Advisory Service - the WorkSafe call centre: freecall 1800 136 089 or (03) 9641 1444
- Your union
- Union Assist - a free service set up and run by the Victorian Trades Hall Council: (03) 9639 6144

## AS THE WORKER YOU NEED TO:

- ✓ Answer all of the questions on this form. The form may be returned to you if it is incomplete
- ✓ Sign the authority to release medical information and worker's declaration at the end of this form. The form cannot be accepted without your signature
- ✓ Keep a copy of all documents for your records
- ✓ Notify your employer as soon as possible that you've been injured at work, and complete the injury register at your workplace. You can also notify the Agent directly by sending them the "early notification" copy of this form
- ✓ Report the accident to the police if your injury was the result of a motor vehicle accident. Otherwise your claim may not be valid
- ✓ Give this form (when completed) to your employer as soon as possible after being injured. If you have difficulty giving this claim to your employer, or your employer refuses to take receipt of the claim form, you can send it directly to the Agent or WorkSafe if the Agent is not known
- ✓ See your medical practitioner to obtain a *WorkSafe Certificate of Capacity (medical certificate)* if you are unable to work and want to claim weekly payments, and give the original copy to your employer along with this form. It is a good idea to check that all of the injuries or illnesses that you are claiming for on this form are listed on the *WorkSafe Certificate of Capacity*
- ✓ Note that if your claim is accepted, WorkSafe can pay the reasonable costs of medical and like expenses. However, this may not mean payment of the full costs. In some cases there may be a gap between what the provider charges you and what WorkSafe can pay as reasonable costs. If you want to know the reasonable costs for a particular service, visit the WorkSafe website at [worksafe.vic.gov.au](http://worksafe.vic.gov.au).
- ✓ Read the statement on the back of this form that explains how your personal and health information will be collected and used and how your weekly payments will be calculated (if your claim is accepted).

## GETTING BACK TO WORK

- Talk with your employer to plan your return to work
- Talk to your medical practitioner or healthcare provider about what parts of your work you could do and any limitations you have. You can also encourage your medical practitioner or healthcare provider to talk to your employer about your capacity for work and any suitable duties that may be available
- Talk to the Agent about what support is available to help you return to work and overcome your injury as quickly as possible

## YOUR EMPLOYER'S RESPONSIBILITIES:

- To confirm to you in writing that you notified them of this claim (they can do this by giving you a copy of this form when signed and completed)
- If you are claiming weekly payments, they must send the completed form and any *WorkSafe Certificates of Capacity (medical certificates)* to the Agent as soon as possible, but no later than 10 days after receiving them from you - or they may be financially penalised
- To pay you weekly payments if your claim is accepted and you have an entitlement
- To work with you to plan your return to work (if required)
- To provide you with suitable employment when you have a capacity to work
- To provide you with pre-injury employment when you have recovered and no longer have an incapacity for work
- To appoint a return to work coordinator who is competent to support your return to work.

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

The WorkSafe Agent will write to you and advise you if your claim is accepted.

A decision to accept or reject your claim will usually be made within 28 days from the Agent received date.

To find out more about making a claim, and what support is available to help you return to work, talk to the Agent, refer to the brochure *Introducing WorkSafe, a guide for injured workers*, or visit the WorkSafe website at [worksafe.vic.gov.au](http://worksafe.vic.gov.au).



# 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)

- |                                    |                                    |  |                                    |
|------------------------------------|------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Full-Time | <input type="checkbox"/> Part-Time | <input type="checkbox"/> Apprentice    | <input type="checkbox"/> Student   |
| <input type="checkbox"/> Contract  | <input type="checkbox"/> Trainee   | <input type="checkbox"/> Agency worker | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Permanent | <input type="checkbox"/> Temporary | <input type="checkbox"/> Seasonal      | <input type="checkbox"/> Jockey    |

Other?

When did you start working for this employer?

 /  / 

Please indicate if any of the following apply to you:

- |                              |                             |                                     |
|------------------------------|-----------------------------|-------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A Director of my employer's company |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A Partner in my employer's company  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A sole trader                       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> 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 service 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



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Given names

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Date of birth

Gender

/  /

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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

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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)

- |                                    |                                    |  |                                    |
|------------------------------------|------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Full-Time | <input type="checkbox"/> Part-Time | <input type="checkbox"/> Apprentice    | <input type="checkbox"/> Student   |
| <input type="checkbox"/> Contract  | <input type="checkbox"/> Trainee   | <input type="checkbox"/> Agency worker | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Permanent | <input type="checkbox"/> Temporary | <input type="checkbox"/> Seasonal      | <input type="checkbox"/> Jockey    |

Other?

When did you start working for this employer?

 /  / 

Please indicate if any of the following apply to you:

- |                              |                             |                                     |
|------------------------------|-----------------------------|-------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A Director of my employer's company |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A Partner in my employer's company  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A sole trader                       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> 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 service 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

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# WORKER'S INJURY CLAIM FORM

Please indicate in which State you want to lodge this claim:

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## 1 WORKER'S PERSONAL DETAILS

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Given names

Other known or previous legal names *eg. Maiden name*

Date of birth Gender

/  /   Male  Female

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Suburb

State Postcode

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M  W  H

E-mail address

If you need an interpreter, what language do you speak?

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Suburb

State

Name of employer responsible for this workplace

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/  /   AM  
PM

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/  /

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PM

When did you report the injury/condition to your employer?

/  /

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Postcode

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*eg. Name of return to work coordinator*

  


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When did you start working for this employer?

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*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  \$

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*\* This question is required for NSW claims*

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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

  
  


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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?

  
  


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Date

  /  / 

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 /  / 

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 /  / 

*\*This question is required for Victorian claims*

Date claim form forwarded to Agent

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Estimated cost of claim to date

 \$

How many days have been lost?

 days  hrs

Employer's signature

Date

  /  / 

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Position

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Given names

Other known or previous legal names *eg. Maiden name*

Date of birth

Gender

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Male  Female

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State

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### 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)

- |                                    |                                    |  |                                    |
|------------------------------------|------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Full-Time | <input type="checkbox"/> Part-Time | <input type="checkbox"/> Apprentice    | <input type="checkbox"/> Student   |
| <input type="checkbox"/> Contract  | <input type="checkbox"/> Trainee   | <input type="checkbox"/> Agency worker | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Permanent | <input type="checkbox"/> Temporary | <input type="checkbox"/> Seasonal      | <input type="checkbox"/> Jockey    |

Other?

When did you start working for this employer?

 /  / 

Please indicate if any of the following apply to you:

- |                              |                             |                                     |
|------------------------------|-----------------------------|-------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A Director of my employer's company |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A Partner in my employer's company  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A sole trader                       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> 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 service 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

# WORKER'S INJURY CLAIM FORM

## COLLECTION OF PERSONAL AND HEALTH INFORMATION TO MANAGE YOUR CLAIM\*

In processing your claim, the Victorian WorkCover Authority (WorkSafe) and any WorkSafe Agent acting for WorkSafe in relation to your claim may collect personal and health information about you. WorkSafe and its Agents are required by law to ensure that all people about whom they collect personal and health information are provided with the following information:

WorkSafe is a body corporate established under the *Accident Compensation Act 1985*. Agents are appointed by WorkSafe under that Act to act on its behalf in managing workers' compensation policies and claims for compensation.

Personal and health information about you is collected 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 WorkSafe or your employer's Agent. Personal and health information collected about you is used for the purpose of processing, assessing and managing your claim and to verify any evidence you may submit in support of the claim. The information may also be used for one or more of the purposes listed in section 243 of the *Accident Compensation Act 1985*, for the purposes of legal proceedings arising under that Act, to assist with your rehabilitation and return to work and to assist WorkSafe and Agents to better manage claims generally.

For the purposes of processing, assessing and managing your claim, WorkSafe and your employer's Agent may disclose personal and health information about you to each other and to the following types of organisations:

- employees, contractors and agents of WorkSafe and Agents
- your employers
- solicitors, medical practitioners and other health service providers, private investigators, loss adjusters and other service providers acting on behalf of WorkSafe or the Agent in relation to the claim
- the Accident Compensation Conciliation Service and Medical Panels
- a court or tribunal in the course of criminal proceedings or any proceedings under any of the Acts which WorkSafe administers
- 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 *Accident Compensation Act 1985*. If you do not provide any part or all of this information, your claim may not be accepted or processed. You may request access to personal and health information about you collected by WorkSafe or your employer's Agent by contacting your employer's Agent.

WorkSafe's policies for managing personal and health information are set out in its Privacy Policy, which is available from your nearest WorkSafe office or at the WorkSafe website at [worksafe.vic.gov.au](http://worksafe.vic.gov.au). Information relating to your right to access your WorkSafe claim information is also available at the website.

(\*If your injury employer is an approved self-insurer, references to 'WorkSafe' and 'Agent' should be read as if they were references to 'self-insurer' and 'approved agent of a self-insurer'.)

## CALCULATING YOUR ENTITLEMENT TO WEEKLY PAYMENTS

Weekly payments are calculated based on your pre-injury average weekly earnings (PIAWE), generally in the 52 weeks before your injury. If you have been with your employer for less than 52 weeks, your PIAWE will be your average weekly earnings in the period of actual employment.

### What information your employer needs to provide about your earnings

To enable the WorkSafe Agent to calculate your PIAWE, your employer will need to provide details of the following payments made to you in the past 52 weeks of your employment, or if that was less than 52 weeks, in the period of your actual employment.

- Base rate of pay
- Overtime and shift allowances
- Piece rates, tally bonuses and commissions
- Non-pecuniary benefits including residential accommodation, use of a motor vehicle, payment of health insurance or payment of education fees
- Any salary sacrifice arrangements

Your employer will also need to tell the Agent if, in the 52 week period before the injury, your earnings increased due to a promotion, or if they decreased due to you voluntarily reducing your hours or changing the nature of your work with the employer.

If your earnings include any other items not listed above, please discuss this with your Agent.