INJURY NOTIFICATION/REGISTER OF INJURY FORM

Facsimile Number 6230 0512 e-mail earlynotification.act@cgu.com.au

Employer Information	
Name (as per policy):	
Address:	Post Code:
Policy Number:	Employer ABN:
Employer Contact:	
Phone Number:	Fax Number:
Injured Worker Information	
Surname:	First name:
Date of Birth:	Male or Female:
Address:	Post Code:
Phone Number:	Mobile:
Occupation:	
Accident/Injury details	
Date of Accident:	Time of Accident:
Date reported to employer:	Time reported to employer:
Type of Injury/Disease Suffered (eg fracture, strain etc):	
Part of body injured (eg lower back, right arm etc):	
Describe how the injury occurred/Cause of Injury:	
Address where accident occurred:	
Has the worker lost any time from work: YES/NO	
Date Ceased:	Date resumed:
Was first aid treatment provided:	
Name of Person providing First Aid:	
Was the accident witnessed:	
Name of Witness:	
Position held:	Phone Number:
Mobile Number:	Fax Number:
Treating Doctor Information	
Name of Medical Practice:	
Name of Doctor:	
Address of Medical Practice/Doctor:	
Phone Number:	Fax:
Signature:	
Name of person reporting/registering injury details:	Employer Signature: Date:
Workers Declaration and Consent: I declare that the above information is correct and hereby authorise any medical practitioner or treatment provider to provide CGU insurance or my employer with any medical information in relation this injury.	Workers Signature: Date: Time:
Privacy: The information provided in this form may be used in relation to any claim you may subsequently lodge and may be disclosed for purposes relating to any claim or as otherwise required by operation of law. Further details relating to our privacy charter can be found on our website at www.cgu.com.au or from any CGU Office.	

Note: Employer must add the details of the injury/disease on the injury register as required under Section 92 of the Workers Compensation Act 1951 (ACT) No 2.