

Section 2 – Claimant's/event details (whether claimant is worker or a dependent of a deceased worker)

3. Title: <i>(please select)</i>	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Dr <input type="checkbox"/> Other _____		
4. Surname or family name:			
5. Given or first name/s:			
6. Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	7. Date of birth <i>(dd/mm/yyyy)</i> :	DD / MM / YYYY
8. Residential address of the claimant:	Unit/Building no.	Street no.	Street name
	Suburb/Town/Locality		State Postcode
9. Has the claimant ever been known by another name?			<input type="checkbox"/> Yes <i>(see below)</i> <input type="checkbox"/> No
Surname or family name:			
Given or first name/s:			

Worker's details <i>(if worker different from claimant)</i>			
10. Title: <i>(please select)</i>	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Dr <input type="checkbox"/> Other _____		
11. Surname or family name:			
12. Given or first name/s:			
13. Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	14. Date of birth <i>(dd/mm/yyyy)</i> :	DD / MM / YYYY
15. Residential address of worker at time of event:	Unit/Building no.	Street no.	Street name
	Suburb/Town/Locality		State Postcode
16. Has the worker ever been known by another name?			<input type="checkbox"/> Yes <i>(see below)</i> <input type="checkbox"/> No
Surname or family name:			
Given or first name/s:			

Please note: if a dependency claim (i.e. the injury resulted in the worker's death), complete all relevant questions for each claimant from questions 17 to 33.

If claimant is the deceased worker's spouse	
17. Date of marriage <i>(dd/mm/yyyy)</i> :	DD / MM / YYYY
18. Place of marriage:	

(If you have completed this question, go to question 21.)

If claimant is the deceased worker's de facto			
19. Date on which de facto relationship started <i>(dd/mm/yyyy)</i> :	DD / MM / YYYY		
20. Residential address where de facto relationship started:	Unit/Building no.	Street no.	Street name
	Suburb/Town/Locality		State Postcode

If claimant is the deceased worker's spouse or de facto	
21. Details of any health problems currently suffered by the claimant:	
<hr/> <hr/> <hr/> <hr/> <hr/>	

22. Expected date of birth of any posthumous child/children of the relationship with the worker (dd/mm/yyyy):		DD / MM / YYYY
23. Has claimant married, remarried or entered into a marriage-like relationship since the worker's death?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, date of marriage (dd/mm/yyyy):	DD / MM / YYYY	
24. Was the claimant receiving an income before the worker's death?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, give net (after tax) weekly income from all sources:		
\$	Source	
\$		
\$		
\$		
\$		
\$		
\$		
\$		
\$		
\$		
\$		
25. Was the claimant receiving an income after the worker's death?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, give net (after tax) weekly income from all sources:		
\$	Source	
\$		
\$		
\$		
\$		
\$		
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\$		
\$		
\$		
26. What was the amount of average weekly financial benefit derived by the claimant from the deceased worker before the worker's death and the method of calculating the amount?		\$
Method of calculation:		
27. Did the deceased worker intend to continue working?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, to what age?		
28. Was the intended future employment full- or part-time?		<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time

(If claimant has completed this question, go to question 34.)

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If claimant is not the deceased worker's spouse or de facto

29. Relationship to deceased worker:

30. Details of any health problems currently suffered by the claimant:

31. What are the claimant's current net (after tax) weekly earnings?

\$	Source
\$	
\$	
\$	
\$	
\$	
\$	
\$	
\$	
\$	
\$	

32. What was the amount of average weekly financial benefit derived by the claimant from the deceased worker before the worker's death and the method of calculating the amount? \$

Method of calculation:

33. Would the claimant have been dependent on the deceased worker? Yes No

If yes, to what age?

Basis for dependency:

Worker's employment details at date of event

34. Usual occupation: Full-time Part-time

35. Nature of employment at time of event (if different from usual occupation)

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36. Details of every employer of the worker at the time of the event (include details of self-employment):			
Trading name of employer:			
Business address:	Unit/Building no.	Street no.	Street name
	Suburb/Town/Locality	State	Postcode
Trading name of employer:			
Business address:	Unit/Building no.	Street no.	Street name
	Suburb/Town/Locality	State	Postcode

Details of the event resulting in the 'injury'			
37. Date and time of event <i>(dd/mm/yyyy)</i> :	DD / MM / YYYY		Time: <input type="checkbox"/> am <input type="checkbox"/> pm
38. If over period of time, state <i>(dd/mm/yyyy)</i> :	when the period of the event commenced DD / MM / YYYY	when the period of the event ceased DD / MM / YYYY	when the symptoms commenced DD / MM / YYYY
Date first seen by a health practitioner <i>(dd/mm/yyyy)</i> :	DD / MM / YYYY		

Health practitioner details			
Name:			
Address:	Street no.	Street name	
	Suburb/Town/Locality	State	Postcode
Phone number:			
39. Where did the event happen? <i>(e.g. workshop floor, Smith Street, Bulimba)</i> Please attach a diagram of the location <i>(as relevant)</i>	Place		
	Street no.	Street name	
	Suburb/Town/Locality	State	Postcode

40. Completely describe the details of the event resulting in the injury:

41. Details of employer's representative to whom injury was reported:			
Name:			
Position:			
Address:	Unit/Building no.	Street no.	Street name
	Suburb/Town/Locality	State	Postcode

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Witnesses

42. Was the event witnessed? (provide details of all witnesses) Yes No

Witness 1

Surname or family name:			
Given or first name/s:			
Address:	Unit/Building no.	Street no.	Street name
	Suburb/Town/Locality	State	Postcode
Phone number:			
Email address:			
What is the relationship, if any, of the witness to the worker?			

Witness 2

Surname or family name:			
Given or first name/s:			
Address:	Unit/Building no.	Street no.	Street name
	Suburb/Town/Locality	State	Postcode
Phone number:			
Email address:			
What is the relationship, if any, of the witness to the worker?			

43. Particulars of all injuries alleged to have been sustained because of the event (For injuries occurring on or after 15 October 2013, a notice of assessment *must* be attached.)

Part of the body injured (e.g. right index finger, lower back)	Nature of injury/ies (e.g. fracture, strain)	Has a Notice of Assessment been received?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
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		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

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44. List all doctors, hospitals, rehabilitation and any other service providers from whom the worker received treatment for the injury arising out of the event.

Doctor/hospital name	Address

45. Has the worker sustained any personal injury/ies, illness/es, impairment/s or disability/ies of a medical, psychiatric or psychological nature, either before or since the event, that may affect the degree of permanent impairment resulting from the injury to which the claim relates or may affect the amount of damages in any other way?

- Yes (complete table below)
 No

Injury, illness or impairment	Doctor/hospital name	Address

46. Has the worker ever made a claim, either before or since the event, for damages, compensation or benefits as a result of any personal injury/ies, illness/es or impairment/s of a medical, psychiatric or psychological nature?

- Yes (complete BOTH tables below)
 No

Injury, illness or impairment	Name and address of insurer	Name and address of organisation or person against whom claim was made

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Injury, illness or impairment	Doctor/hospital name	Address

47. How is the worker presently affected by the injury/ies?
(e.g. symptoms suffered, effect at work and away from work including any impact on ability to work. If not affected, write 'nil'.)

Mitigation

48. Has the worker been provided with an assessment or provision of treatment or rehabilitation services? *(e.g. work training, counselling, independent living assistance, exercise program)*
 Exclude details of any rehabilitation provided during the statutory claim as the insurer has this information.

Yes *(complete table below)*
 No

Treatment	Name	Address

49. Provide particulars of all steps, other than rehabilitation, taken by the worker to mitigate loss including but not limited to search for work including listing all applications for employment made by the worker, consulting employment agency, re-training and any reasons why these steps were unsuccessful etc.

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50. Are you currently undertaking any paid or unpaid work with any employer or on a self-employed basis? If yes , please ensure all relevant details including name and address of income source (<i>e.g. employer</i>), any current period of employment/receipt of payment, capacity in which employed (<i>include self-employment or benefit details</i>) and gross and net (<i>after tax</i>) earnings for this period of employment are outlined in Section 3 - Income statement by worker.	<input type="checkbox"/> Yes <input type="checkbox"/> No
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51. Does the worker require any assistance with return to work or rehabilitation in relation to the injury/ies arising from the event and/or any other personal injury/ies, illness/es, impairment/s or disability/ies of a medical, psychiatric or psychological nature?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Please outline any specific assistance required:

Section 3 – Income statement by worker

52. Provide details of employment, including self-employment and income details, for the three years before; for the period since the event resulting in injury; and at the date of signing the Notice of Claim. Any periods during which the claimant was in receipt of payments from the Department of Social Security or Centrelink must be shown. If there are periods of no income, state the periods, provide reason/s why no income was received and methods of financial support during these periods.

Name and address of income source <i>(e.g. employer)</i>	Period of employment/receipt of payment	Occupation and capacity in which employed (<i>include self- employment or benefit details</i>)	Gross and net (<i>after tax</i>) earnings for each period of employment

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Section 4 – Liability

53. Did the worker cause, or contribute to, the event causing the injury?		<input type="checkbox"/> Yes <input type="checkbox"/> No						
54. To what extent of liability on the part of the worker, expressed as a percentage, does the claimant admit?		%						
If the claimant cannot admit liability, provide reasons:								
<hr/> <hr/> <hr/> <hr/> <hr/>								
55. Provide the full particulars of any negligence alleged against the worker's employer:								
<hr/> <hr/> <hr/> <hr/> <hr/>								
56. To what extent of liability, expressed as a percentage, does the claimant hold the employer/s responsible?		%						
57. Is negligence alleged other than against the worker's employer/s? (If yes, complete below and questions 58–60)		<input type="checkbox"/> Yes <input type="checkbox"/> No						
Name:								
Address:								
<table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">Unit/Building no.</td> <td style="width: 33%;">Street no.</td> <td style="width: 34%;">Street name</td> </tr> <tr> <td>Suburb/Town/Locality</td> <td>State</td> <td>Postcode</td> </tr> </table>			Unit/Building no.	Street no.	Street name	Suburb/Town/Locality	State	Postcode
Unit/Building no.	Street no.	Street name						
Suburb/Town/Locality	State	Postcode						
58. Provide the full particulars of any negligence alleged:								
<hr/> <hr/> <hr/> <hr/> <hr/>								
59. To what extent of liability, expressed as a percentage, does the claimant hold that party responsible?		%						
60. If negligence is alleged other than against the worker's employer, has notice of the alleged negligence been given?		<input type="checkbox"/> Yes <input type="checkbox"/> No						
Party 1								
If Yes, date notice given (dd/mm/yyyy):		DD / MM / YYYY						
Name and address of person to whom notice given:								
Name:								
Address:								
<table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">Unit/Building no.</td> <td style="width: 33%;">Street no.</td> <td style="width: 34%;">Street name</td> </tr> <tr> <td>Suburb/Town/Locality</td> <td>State</td> <td>Postcode</td> </tr> </table>			Unit/Building no.	Street no.	Street name	Suburb/Town/Locality	State	Postcode
Unit/Building no.	Street no.	Street name						
Suburb/Town/Locality	State	Postcode						

Section 6 – Worker authority and declaration

I, _____
Name of claimant, address, suburb/town and postcode

declare under the *Workers' Compensation and Rehabilitation Act 2003* that all statements made in this Notice of Claim for Damages that are in my personal knowledge, are true, correct and complete in every respect.

I acknowledge that it is an offence under the *Workers' Compensation and Rehabilitation Act 2003* to make a statement that is false or misleading. The information I have provided is true and not misleading. I have not omitted any information which would make any of the above false or misleading.

I acknowledge my duty to mitigate loss and my obligation to satisfactorily participate in rehabilitation, any return to work program or suitable duties arranged or facilitated by the insurer under the *Workers' Compensation and Rehabilitation Act 2003*.

I agree to advise the insurer if my circumstances change or if I become aware of any matter that would make the above information false or misleading including any return to work (including any paid or unpaid work with any employer or on a self-employed basis).

I authorise any hospital, ambulance service of the state or another state, a doctor, provider of treatment or rehabilitation services or person qualified to assess cognitive, functional or vocational capacity or an employer, or previous employer or insurers that carry on the business of providing workers' compensation insurance, compulsory third party insurance, personal accident or illness insurance, insurance against the loss of income through disability, superannuation funds or any other type of insurance or a department, an educational and/or academic institution, agency or instrumentality of the Commonwealth or the State or a solicitor, to release any information or documents relevant to my claim for damages other than where giving information would breach legal professional privilege.

Claimant's signature

Declared before me:

Signature of Justice of the Peace or Commissioner for Declarations or Solicitor

Date DD / MM / YYYY at _____ (place)

Justice of the Peace or Commissioner for Declarations or Solicitor (see below)

Name:			
Address:	Unit/Building no.	Street no.	Street name
	Suburb/Town/Locality	State	Postcode
Telephone:			

Where a lawyer may sign: A lawyer may sign on behalf of the claimant **only** where there is an urgent need to commence proceedings AND where it is not reasonably practicable for the claimant to sign.

I, _____

legal representative of the claimant, _____

sign this Notice of Claim on behalf of the claimant because it is not reasonably practicable for the claimant to do so.

Signature Date

Lawyer's contact details

Name of firm:			
Address:	Unit/Building no.	Street no.	Street name
	Suburb/Town/Locality	State	Postcode
Telephone:			

Privacy statement:

Under the *Workers' Compensation and Rehabilitation Act 2003* and earlier Queensland workers' compensation legislation, the workers' compensation insurer is authorised to collect the information on this form to process the notice of claim. Some or all of the information contained in this form may be disclosed to the claimant's employer, another insurer, medical or allied health providers or any other workers' compensation authority in any jurisdiction.

This form was approved by the Workers' Compensation Regulator, on 1 May 2014, pursuant to section 586 of the *Workers' Compensation and Rehabilitation Act 2003*.

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PN12416