* Before making a claim, workers need to see a doctor and get a *Work capacity certificate – workers’ compensation*
* Workers are encouraged to notify their employer about injuries
* Make a claim as soon as possible. We will then decide the claim based on workers’ compensation legislation and advise you of the outcome.

Make a claim

**Online** at www.worksafe.qld.gov.au

**By phone** on 1300 362 128

**By fax** to 1300 651 387

**By post** to GPO Box 2459, Brisbane Qld 4001.

**Through a doctor**

Section A: Tell us who you are

[ ]  an injured worker

[ ]  an employer

[ ]  an injured worker and employer filling the form in together

Section B: Worker’s details

Family name

1

|  |
| --- |
|       |

Given names Title

2

|  |  |  |
| --- | --- | --- |
|       |  |  |

Previous name/s (if applicable)

3

|  |
| --- |
|       |

Date of birth   /  /

4

Gender [ ]  male [ ]  female [ ]  unspecified

5

Current residential address

6

|  |
| --- |
| Number and street       |
| Suburb/town        | Postcode      |

Postal address

7

If this is the same as the residential address please write ‘as above’

|  |
| --- |
| Number and street       |
| Suburb/town        | Postcode      |

Contact details

8

|  |  |
| --- | --- |
| Home telephone        | Work telephone       |
| Mobile number       |
| Email address       |

What is the claim for?

9

[ ]  time off work (other than the day of the injury)

If your claim is accepted, you will need to complete a Tax file number declaration

[ ]  medical expenses

quick info

Worker’s bank details

10

We pay claim and medical reimbursement payments by electronic funds transfer

|  |
| --- |
| Name of bank       |
| BSB number     -     | Account number       |
| Account name       |

Section C: Employment details

Employer’s name and business address

11

|  |
| --- |
| Name       |
| Who to contact       |
| Number and street       |
| Suburb/town        | Postcode      |
| Telephone        |
| Email       |
| WorkCover policy number or ABN (if known)       |

Worker’s job title

12

|  |
| --- |
|       |

Was the worker any of the following at the time of the injury?

132

[ ]  a community service worker [ ]  a director of a corporation

[ ]  a jockey [ ]  a member of a partnership

[ ]  a student [ ]  a trustee of a trust

[ ]  a contractor [ ]  self-employed

[ ]  a worker for another employer [ ]  a volunteer or unpaid intern

Section D: Injury details

When did the injury happen?

14

|  |
| --- |
| Date   /  /     Time   :   [ ] am [ ] pm |

What is the nature of the injury and part of the body that is injured?

15

e.g. cut right index finger, fractured leg, lower back strain

|  |
| --- |
|       |

How did the injury happen?

16

e.g. lifting steel rods from the floor to a bench

|  |
| --- |
|       |

Where did the injury happen? e.g. workshop floor

17

|  |
| --- |
| Place       |
| Number and street       |
| Suburb/town        | Postcode      |

Did the injury happen:

18

[ ]  working at the normal workplace

[ ]  in a road traffic accident while working

[ ]  at work on a break

[ ]  on a journey to or from work

[ ]  away from work during a recess period

[ ]  working away from the normal workplace

If the injury was reported to the employer, what date was it reported?

19

|  |
| --- |
| Date   /  /     |

Who was the injury reported to?

|  |
| --- |
| Name       |

Has a work capacity certificate been attached to this form?

**20**

[ ]  yes, go to question 21

[ ]  no, fill in the details below

|  |
| --- |
| Date the doctor signed or issued the certificate?   /  /     |
| Diagnosis       |
| Doctor’s name       |
| Practice/hospital name       |
| Date first seen   /  /     |

Worker’s capacity for work

[ ]  fit to return to normal duties from

|  |
| --- |
| Date   /  /     |

[ ]  fit for suitable duties and/or restricted hours from

|  |
| --- |
| Date   /  /     to   /  /     |
| Restriction/s       |

[ ]  not able to work at all from

|  |
| --- |
| Date   /  /     to   /  /     |

Treatment

[ ]  no further treatment required

[ ]  will require treatment from

|  |
| --- |
| Date   /  /     to   /  /     |
| Treatment required       |

Section E: Employer and wages information

*This section does not need to be completed for a valid application to be made, however it may assist us to make a quicker claim decision if it is completed*

Employers only: do you agree the event occurred at work (or on the worker’s way to or from work) and that the worker suffered an injury as a result of that event?

21

[ ]  yes

[ ]  no: provide relevant information to help us determine the claim

|  |
| --- |
|       |

Worker’s wages/salary

**22**

|  |
| --- |
| How many hours per week       hrs |
| Gross weekly rate of salary/wages (under EBA/award) $      |
| Gross normal weekly earnings $      |

The wage payments calculator is available at www.worksafe.qld.gov.au

Worker’s hours of work each day of the week

**23**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Mon** | **Tues** | **Wed** | **Thurs** | **Fri** | **Sat** | **Sun** |
|       |       |       |       |       |       |       |

Has the employer excess been paid to the worker?

**24**

[ ]  no [ ]  yes, gross amount paid $

Has the employer continued to pay the worker’s salary or wages during the period of incapacity (in addition to the excess)?

**25**

[ ]  no [ ]  yes, provide employer’s bank details for EFT reimbursement

|  |
| --- |
| Bank name       |
| BSB number     -     | Account number       |
| Account name       |

If the employer is not entitled to claim back all of the GST, what percentage can be claimed?      %

**26**

Reference code or payroll number for the worker

**27**

|  |
| --- |
|       |

### Important information—read before agreement

This section needs agreement by the person completing the form. If the worker and employer are completing the form together, please complete both sections.

Section F: Privacy notice and statements

Privacy

WorkCover Queensland (WorkCover) is collecting your personal information under the provisions of the *Workers’ Compensation and Rehabilitation Act 2003* to assess your entitlement to compensation and manage your claim throughout its duration. WorkCover may give some of your information to your employer, the Workers’ Compensation Regulator and relevant service providers for the purpose of payments, treatment, rehabilitation and return to work.

Your information will be treated in accordance with the *Information Privacy Act 2009* and will not be given to any other person unless authorised or required by law. For more information on privacy, visit our website at [www.worksafe.qld.gov.au/about-us/publication-scheme/privacy/privacy-statement](http://www.worksafe.qld.gov.au/about-us/publication-scheme/privacy/privacy-statement) or call us on 1300 362 128.

Workers statement

I acknowledge that it is an offence against 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 agree to advise WorkCover Queensland if my circumstances change or if I become aware of any matter that would make the above information false or misleading. I will advise WorkCover Queensland if I undertake any employment (paid or unpaid), including self-employment, during my claim.

I authorise any doctor, health authority, allied health provider, rehabilitation provider, or other insurer to disclose to WorkCover Queensland and its agents any information about my medical history relevant to this claim.

I have read and understand the privacy notice.

|  |
| --- |
| Full name       |
| Date   /  /      | [ ]  I agree |

Employer’s statement

*This section does not need to be completed for a valid application to be made, however it may assist us to make a quicker claim decision if it is completed*

I have read the information provided with this form. I acknowledge that it is an offence against the *Workers’ Compensation and Rehabilitation Act 2003* to make a statement that is false or misleading. The information that I have provided is true and not misleading.

I have read and understand the privacy notice.

|  |
| --- |
| Full name       |
| Date  /  /     | [ ]  I agree  |

What’s next

We will SMS the injured worker their claim number when we receive the claim (if a mobile number is provided).

After you lodge your claim, we have 20 business days to make a decision on the claim, but we decide most claims within five days.

If the claim is accepted, it may be managed by one of our customer service centres to assist with return to work. If the claim is for time off work, the injured worker will be required to complete a *Tax file number declaration* and send it to us.

If you have any questions about your claim or workers’ compensation in Queensland, call us on 1300 362 128 or visit our website at www.worksafe.qld.gov.au.