



# EMPLOYER INJURY CLAIM REPORT

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

New South Wales  Queensland  Victoria

## 1 EMPLOYER'S DETAILS

Legal name

Trading name

Employer's scheme registration number

*eg. WorkSafe Employer, Policy, or Employer Registration Number*

Employer's reference number *(Your reference)*

*\* This question is required for NSW claims*

*\* Policy period of insurance*

/  /  to  /  /

Street address

  


Suburb

State

Postcode

 

Postal address

  


Australian Business Number

ACN/ARBN

Division

Cost Centre

 

What is the main business activity at the incident site?

Name, position, and daytime contact number of employer contact

  
  


Name and daytime contact number of the return to work coordinator (if any)

  
  


Address for correspondence relating to this claim

Postal address

  


State

Postcode

 

Employer contact e-mail address

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

When did you receive the worker's completed claim form?

/  /

When did you receive the worker's first medical certificate?

/  /

## 2 WORKER'S DETAILS

Family name

Given names

Street address

  


Suburb

Postcode

 

Daytime contact phone number/s

M  W  H

Date of birth

Gender

/  /   Male  Female

## 3 WORKER'S EMPLOYMENT DETAILS

Street address of the worker's usual workplace

  


Suburb

State

Postcode

 

*This question is required for NSW claims*

How many workers are employed at this workplace?

*This question is required for Victorian claims*

Workplace number for worker's usual workplace

If the incident did NOT happen at one of your workplaces, please give the name of the employer responsible for the workplace

Employer's name

What is the worker's usual occupation?

What are the main tasks performed by the worker in their usual occupation?

  
  


Which of the following apply to the worker?

*(Please tick all relevant boxes)*

- Full-Time  Part-Time  Apprentice  Student  
 Contract  Trainee  Agency worker  Volunteer  
 Permanent  Temporary  Seasonal  Jockey

Other?

When did this worker start working for you?

/  /

*\* These questions are required for NSW and QLD claims*

Is the worker employed under any of the following?

- Federal award  Registered industrial agreement  
 State award  No agreement or award  
 WCA Jobcover Program  Registered enterprise agreement

\* What is the title of the award or agreement?

What is the worker's minimum weekly wage?

*As specified by the award or agreement*

\$

## 4 WORKER'S RETURN TO WORK DETAILS

If the worker has returned to work, please provide the date

/  /

What duties are they doing?

Full

Suitable/Modified

How many hours do they work each week?  hrs

How many days have been lost?  days  hrs

Have you provided the worker with a return to work plan, taking into account the injury/condition?

Please attach a copy of the return to work plan or agreement, or please explain why you have not provided a plan.

  
  


If the worker has not returned to work, do you know of any issues that would delay or prevent a return to work?

  
  


### 5 CLAIM CONFIRMATION DETAILS

Do you agree that the details provided in sections 2 & 4 of the Worker's Injury Claim Form are correct?  Yes  No

Do you accept that your worker has an injury/condition which is work-related and occurred while in your employment?  Yes  No

Note: If you agree the injury is work-related, and believe that the details provided in sections 2 & 4 of the Worker's Injury Claim Form are correct, you do not need to complete the remainder of this form except for section 9, which MUST be completed. Otherwise, please complete any relevant questions in sections 6, 7 and 8 of this Report.

### 6 WORKER'S EARNING DETAILS

Please complete this section if you wish to claim for weekly payments

How many standard hours did the worker work each week before being injured? Exclude overtime  hrs

What were the worker's usual working hours? For example, Monday to Friday, 8.30 am to 5.30 pm

What was the worker's usual gross hourly rate? Exclude overtime & shift allowances \$

What was the worker's usual gross weekly earnings? Exclude overtime & shift allowances \$

Please provide details of any overtime or shift work

Average weekly overtime  hrs \$

Weekly shift allowance \$

Please provide payroll records covering the 12 months prior to injury

### 7 INCIDENT DETAILS

What is the worker's injury/condition, and which parts of the body are affected?

  
  


What happened and how was the worker injured?

  
  
  


What is the street address where the incident occurred?

  


Suburb

State

What date and time did the injury occur?

 /  /  AM  
 PM

What date and time did the worker first cease work?

 /  /  AM  
 PM

Which of the following incident circumstances apply?

- While working at the usual workplace
- While working away from the 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 working\*

\* For NSW incidents a journey claim form must also be completed

If the injury was the result of driving or using a motor vehicle or the use of public transport, please provide the registration number/s of any vehicles involved

 State 

Has the worker had a similar injury/condition or personal injury claim before that relates to this injury/condition?

Please give details, including claim numbers

  
  


When did the worker report the injury to you?

 /  / 

Who was the injury reported to?

  


What are the names and daytime contact details of any witnesses?

  
  
  


Do you believe that the injury/condition was caused or contributed to by the worker, or a third party such as a manufacturer or supplier? Please give details if relevant

  
  
  
  


### 8 ADDITIONAL INFORMATION

Do you want to provide any additional information that may assist in the determination of liability or the management of this claim? eg. Do you dispute liability, and, if so, why?

  
  
  


### 9 EMPLOYER'S DECLARATION

I have read the information provided in this form. I declare that the information I have supplied in this form, and any attachment to this form, is true and correct and that no information has been suppressed or omitted from this report to the best of my knowledge. I understand that the making of a false or misleading statement concerning a claim is punishable by law and that I may be prosecuted.

Signature of employer's representative Date

 /  / 

Name

Position