

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"/> Casual | <input type="checkbox"/> Student |
| <input type="checkbox"/> Full-Time | <input type="checkbox"/> Part-Time |
| <input type="checkbox"/> Apprentice | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Contract | <input type="checkbox"/> Trainee |
| <input type="checkbox"/> Agency worker | <input type="checkbox"/> Contractor |
| <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 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

Payment details

WorkCover Queensland makes compensation and benefit payments by electronic funds transfer (EFT). You must complete this section to receive payments if your application is accepted.

This payment section of the form will only be used to process compensation and benefit payments once an application is accepted.

The information you provide in this section is confidential. Your banking details will only be used during your claim.

If you do not complete your banking details now, WorkCover Queensland will need to collect these details from you before we can make a payment by EFT. This will delay you receiving compensation and benefit payments.

Personal details

1 Surname or family name

2 Given names

Title

3 Current residential address

Bank details

4 Name of bank, building society or credit union

5 Branch where your account was opened

6 Type of account (e.g. cheque or savings)

7 BSB number

Please see the information pages for assistance if needed

8 Account number

9 Account held in the name/s of

Special note: If you are providing a copy of this completed form to your employer, you may want to remove this page so that your banking details remain confidential.

Applicant's signature

Full name

Date

Important information

Before you send this form, please check that you have:

- read the information provided with this form
- answered all of the relevant questions
- read the applicant's statement section
- included your *Workers' Compensation Medical Certificate/s*
- included your *Tax File Number Declaration* (If required)
- signed this form.

If you have ticked all these boxes, you can lodge your *Worker's Injury Claim Form* with WorkCover Queensland.

How do I lodge my application?

Once you have completed and signed your application, you need to send the form, your *Workers' Compensation Medical Certificate/s* and your *Tax File Number Declaration* to WorkCover Queensland.

By fax

You do not need to use a cover page when you fax your *Worker's Injury Claim Form* to WorkCover Queensland.

Please put your documents in this order:

- 1 *Worker's Injury Claim Form*
- 2 Payment details form (*you need to detach this from your application form*)
- 3 Your *Workers' Compensation Medical Certificate/s*
- 4 Your *Tax File Number Declaration* (if required).

You can then fax your application to WorkCover Queensland on **1300 651 387**. You do not need to send WorkCover Queensland the originals of your fax. You can keep the originals for your own records.

By post

Post your completed application documents to GPO Box 2459, Brisbane Qld 4001.

More information

If you have any questions about completing or lodging this form, or about the claims process, you can call WorkCover Queensland on **1300 362 128**.

1 WORKER'S PERSONAL DETAILS

Title **MR** Family Name **CITIZEN**

Given names **JOHN**

Other known or previous legal names eg. Maiden name

Date of birth **01/04/80** Male Female

Residential street address **1 SAMPLE STREET**

Suburb **SAMPLEVILLE**

State **VIC** Postcode **3000**

Postal address for correspondence **AS ABOVE**

What are your daytime contact phone number/s? **M 555 0000 W 555 0001 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?

TORN BICEP MUSCLE IN RIGHT ARM

What happened and how were you injured?

WHILE LIFTING BOXES OFF CONVEYOR AND PLACING THEM ONTO PALLET I FELT A SHARP PAIN IN RIGHT ARM

What task/s were you doing when you were injured?

UNLOADING CONVEYOR

What area of the worksite were you working in when you were injured?

DESPATCH

What is the street address where the incident occurred?

99 MAIN ROAD

Suburb **SAMPLEVILLE**

Name of employer responsible for this workplace **A. HAZARD PTY LTD**

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

3 WORKER'S EMPLOYMENT DETAILS

Name of organisation paying your wages when you were injured **A. HAZARD PTY LTD**

Street address of your usual workplace **99 MAIN ROAD**

Suburb **SAMPLEVILLE**

State **VIC** Postcode **3000**

Name and daytime contact number of employer contact eg. Name of return to work coordinator **A. PAIN 555 0002**

What is your usual occupation? What do you do?

STOREMAN

Which of the following apply to you? (Please tick all relevant boxes)

Full-Time Part-Time Casual Student

Contract Trainee Agency worker Volunteer

Permanent Temporary Seasonal Jockey

Other?

When did you start working for this employer?

29/02/00

Please indicate if any of the following apply to you:

Yes No A Director of my employer's company

Yes No A Partner in my employer's company

Yes No A sole trader

Yes 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

NO

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 **38** hrs

What were your usual working hours? For example, Monday to Friday, 8.30 am to 5.30 pm

MON - FRI 6AM - 3PM

What was your usual pre-tax hourly rate? Exclude overtime & shift allowances \$ **18**

What were your usual pre-tax weekly earnings? Exclude overtime & shift allowances \$ **684**

* 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 **DR MICHAEL** Phone **555 5555**

Please provide the name, clinic or hospital, and contact details of any medical providers (including Clinics or Hospitals) that have treated your injury

NO

This form can be used to lodge a Workers' Compensation Claim in New South Wales, Queensland, or Victoria

If you have returned to work with your employer, what was the date? **21/4/09**

What duties are you doing? Full Substantive/Modified

How many hours are you working? **38** hrs

Have you returned to work with a new employer? Please provide the name and contact details of the new employer.

NO

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?

21/4/09

How did/will you give this claim form to your employer?

Hand delivered By post

When did/will you give your employer the first medical certificate?

21/4/09

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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 to the relevant authority, the information that I have supplied in this form, and 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 **[Signature]** Date **21/4/09**

* 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 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 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.

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 days / /

How many days have been lost? / /

Employer's signature / /

Name / /

Position / /

Employer's scheme registration number eg. WorkCover Employer, Policy, or Employer Registration Number