WORKERS COMPENSATION EMPLOYER'S REPORT OF INJURY

It is essential that this form be completed to enable the worker's entitlement to compensation to be promptly determined. Payments should not be commenced until authorised by us.
If claim for medical expenses and no time has been lost, complete all questions except questions 12 and 13. Please use "BLOCK" capitals.

Branch

Policy no.

1. Employer Details

Full Name of Employer

Employer's occupation, business or profession

Are you registered for GST purposes?

No ☐ Yes ☐ What is your ABN?

Have you claimed an input tax credit on the GST applicable to this policy?

No ☐ Yes ☐ Is the amount claimed less than 100% of the GST applicable to the premium? No ☐ Yes ☐ Specify the percentage amount claimed %

Address

Postcode

Private telephone no. ( )

Business telephone no. ( )

Facsimile no. ( )

Number of employees

Permanent

Casual

2. Injured Worker

Surname

Given name(s)

Age

Date of birth / /

Married No ☐ Yes ☐

Address

Postcode

Private telephone no. ( )

Worker's occupation

3. Employment Details

Indicate with a "✓" the days usually worked each week. Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday ☐

State standard number of hours worked: Per day hrs mins Per week hrs mins

How long has the worker been in your employ? years months days

1. Was the worker directly employed? (i.e. not a contractor or employee of a contractor) Yes ☐ No ☐
   If the answer is "No", please attach details.
2. Was the worker employed on a casual basis? No ☐ Yes ☐
3. Was the worker employed on a seasonal basis? No ☐ Yes ☐

If the answer to question 2 or 3 is "Yes", please ensure the questions relating to casual and seasonal workers are answered on back page.

4. Nature of Injury

Under 'Nature of Injury' report the type of injury (e.g. fracture, sprain, amputation, etc.) and under 'Part of Body' report, as precisely as possible, the part of the body injured. Where multiple injuries are received, report the nature and Part of Body of each injury and, where known, indicate which injury is the most severe.

Type of Injury (e.g. laceration, sprain etc.)	Part of Body (e.g. head, lower back, etc.)	Side of Body (e.g. left/right)
1.		
2.		
3.		

5. Accident

Date of accident / / Time am/pm Day of week

How long had the employee worked, on the date of the accident, before the injury? hrs mins

Date worker ceased / / Time am/pm

Date first Medical Certificate received by Employer / / at am/pm

Date claim form received from worker / / at am/pm

Was the worker affected by Alcohol or Drugs? No ☐ Yes ☐

6. Cause of Accident

Indicate with a "✓" the occurrence that gave rise to the accident.

a) Arising out of or in course of employment - during meal or other work break. ☐
b) Arising out of or in course of employment - road traffic accident [other than 6(a), (d) or (e)]. ☐
c) Arising out of or in course of employment - other. ☐
d) Away from work during recess period. ☐
e) On periodic or other prescribed journey. ☐

7. Address where accident took place

Address

Postcode

8. Department/section, etc. employed (e.g. welding shop)

9. State the actual process in which the worker was engaged at the time of accident (e.g. cleaning machinery, ploughing, etc.)

10. Describe concisely all the circumstances of the accident and ensure that the type of accident and the agency causing it are reported

Type: Type of accident is the manner in which the injury occurred (e.g. fall, struck by falling object, caught in or between objects, contact with harmful substances, etc.)

Agency: Agency refers to the working environment. (machine, means of transport, substance, etc., causing the accident, e.g. conveyor failed.)

11. Please indicate whether

a) the injury was caused by any defect in ways, works, machinery or plant. No ☐ Yes ☐

Details

b) there was any violation of any statutory or other regulations at the time of injury. No ☐ Yes ☐

Details

c) any serious and wilful misconduct on the part of the worker which contributed to the injury. No ☐ Yes ☐

Details

d) the injury was caused by the negligence of any person. No ☐ Yes ☐

Details

12. Worker's Earnings

Is the worker employed under the terms of a specific Award, or a Registered Industrial Agreement? No ☐ Yes ☐

If "YES" please answer the following questions in full. If "NO" please go to question 13.

Title of Award Agreement

Job Classification in that Award

Award Hourly Rate of Pay as Prescribed by the Award or Registered Agreement $

Actual Hourly Rate of Pay Paid to Worker $

If there is a difference in these figures please provide details of the reasons for the difference and the amounts making up the difference.

Shift Work	$	Over Award payment	$
Bonus	$	Other Allowance	$
Casual Loading	$		

Please advise the average weekly wage earned by the worker in the last 13 weeks. $

If the worker did not work for any part of that 13 week period, that part should be disregarded for the purposes of the calculation.

13. Worker's Earnings

This section is to be completed where the injured worker is not working under an industrial award or registered industrial agreement.

Total earnings in your employment over the last year including all bonuses and allowances. $

If the worker has been employed by you for less than one year, the total weekly earnings in your employment are to be shown.

If the worker has been employed by you for less than one year, state the number of weeks employed by you.

14. Reporting of Accident

Name of person to whom the accident was reported

Date reported / /

Time am/pm

Name of witness, if any

Address of Witness

Postcode

If more than one witness, please attach a list on a separate page.

Do you agree with the details of the occurrence as provided on the Workers Claim for Compensation Form?

No ☐ Yes ☐ If 'no', please give details

15. Result of Injury

Enter the result as known at the time of completing this report. 'Permanent total disability' relates to claims where the worker is considered to be totally and permanently incapacitated for any type of work. 'Permanent partial disability', relates to cases of complete or partial loss of, or loss of the use of, any part of the body or body faculty, as a result of which, although able to work, the earning capacity of the worker, or his/her opportunities for employment (in his/her normal occupation or in any other capacity), are permanently affected.

Please tick (✓) in the appropriate box. Death ☐ Permanent total disability ☐
Temporary disability ☐ Permanent partial disability ☐

Has the worker resumed work? Yes ☐ Date / /

No ☐ Estimated period of incapacity
Weeks Days

Have you any other duties which the worker could perform until he/she can resume his/her pre-injury duties?

No ☐ Yes ☐ Please provide details

Signature of the employer **Date** / /

Please attach additional comments on a separate sheet.

16. Information Required for Casual or Seasonal Workers

Please state:

1. The number of weeks he/she has worked for you over the past year.
2. If the worker has not worked for you for a full year, please give the following information.

Name of Employer	Telephone no.	Dates Worked
		From to
		From to
		From to
		From to

Please add any additional comments on a separate page and attach to this form.

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