Employer's Report of Injury

DO YOU SUPPORT THIS CLAIM Yes ☐ No ☐

Important Please Read

Level 9, 66 St Georges Terrace, Perth WA 6000. GPO Box B50 Perth WA 6001. Telephone (08) 9320 3600 Facsimile (08) 9320 3650

COMPLETE ALL QUESTIONS, PARTIALLY COMPLETED FORMS WILL BE RETURNED. (Print in block letters and circle where appropriate.)

Employer details

Full name as per policy

Trading Name | Policy No. WA

Telephone No. | Fax No. | Email

Postal Address: | Postcode

Name of Site and/or Location address where injured person actually works | Cost centre

Business Activity/Profession *(use 2 words or more)*

Injured person's details

Surname | Given Names

Address

Postcode | Telephone No.

Date employed / / | Place of birth

Date of birth / / | Height | Weight

Sex: Male ☐ Female ☐ Employed: Full Time ☐ Part Time ☐ Casual ☐ Marital Status: Married/De facto ☐ Single ☐

Occupation | Is injured person a contractor or subcontractor? Yes ☐ No ☐

(If "YES", attach a copy of any written agreement or contract, together with twelve months of their invoices if applicable.

Is she/he a director or family member? Yes ☐ No ☐ If "Yes", please tick which Director ☐ Family member ☐ If a family member, does she/he live with the Insured? Yes ☐ No ☐

Injury details

Date of injury / / | Time of injury am/pm | Date Employee Claim form received / /

To whom was accident reported | Position | Date first medical received / /

Name and address of witness | Postcode

Location address where injury occurred | Postcode

Where did the accident occur? At work ☐ During work break ☐ Away from work during a break ☐

Motor vehicle accident whilst working ☐ Travelling to or from place of employment ☐

Injury details continued

How did the injury occur?

What was the injured person doing at this time?

Was the injured person performing his/her normal duties? Yes ☐ No ☐

If "No", why were they doing this task?

Is protective equipment/clothing required for the task? Yes ☐ No ☐

If "Yes", what type?

Was the above clothing/equipment being worn at the time of the injury? Yes ☐ No ☐

If "No", why?

Is this a recurrence/aggravation? Yes ☐ No ☐

If "Yes", provide details of previous injury including the Insurer's claim number if known?

Describe the injured person's injury or condition (e.g. laceration, dermatitis)

Which part of the body is injured (e.g. left upper arm, right ankle)

Was First Aid treatment given? Yes ☐ No ☐

If "Yes", by whom?

What treatment was provided and for what period?

Name of Doctor first attended

Hospital admitted to and date

Give details of any other circumstances that would assist GIO to assess the claim.
(Include in here queries as to the validity of the claim e.g. misconduct, skylarking or pre-existing disabilities contributing to the injury or accident.) In my opinion:

Time loss details (show N/A if there is no lost time)

Date ceased work	Time	Date work resumed	Time	If work has not been resumed what is anticipated date of return
/ /	am/pm	/ /	am/pm	/ /

Weekly compensation (complete only if there is or will be lost time [e.g. surgery anticipated])

How many days per week? and hours per day? does the injured person work? Yes ☐ No ☐

What is the start time? and finish time? Is this the same every day? Yes ☐ No ☐

If "No", please provide details

Please show whether the injured person is employed under: 1. Industrial Award ☐ or 2. Other ☐

If option 1:

What is the full name of the Award? is it: State or Federal?

Weekly compensation continued

Please also complete the 13 weeks wage information below to enable us to advise you of the correct rate of pay or provide a print-out of payment records.

Week No	Week Ending	No. of Hours Worked	Award Rate $	Overtime $	Allowances $	Other $	Total $
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
			AVERAGE (+13) $			GRAND TOTAL $	

If option 2: Please provide the total amount paid to the injured person during the 12 months immediately prior to the accident or for such lesser period as applies and ensure that the "Date Employed" is completed in the "Injured Person's details" section on page 1.

Total "wages" paid $ _____ for _____ weeks (please provide print out of pay records)

Rehabilitation

The Injury Management Process in Western Australia requires consultation between the employer, the medical practitioner and the injured person before the injured worker is referred to an approved rehabilitation provider for an assessment. An employer is able to authorise their insurer to act on their behalf in the consultation process with the medical doctor to support the employee in their appointment of an approved vocational rehabilitation provider for a vocational assessment.

Do you have a delegated rehabilitation coordinator? Yes ☐ No ☐ If Yes, name _____ telephone no. _____

Has injury management commenced? Yes ☐ No ☐ If Yes, what actions have been taken _____

Signature _____ Position _____ Date / /

Employer's Declaration

I, (print name, position)

_____

declare that the details above are true and correct in every particular. Signature _____ Date / /

EMPLOYERS PLEASE NOTE

1. a) This notice of claim must be forwarded within 3 days of lodgement of claim by the injured person. This also applies to any documentation received in respect of the claim.

   b) Please attach Employee Claim Form 2B and 1st Medical Certificate.

2. If the injured person has not resumed work at the time of lodgement of this claim, it is important that you notify the insurer immediately the injured person returns to work.

3. No compensation or any other payments e.g. medical are to be made without prior written approval of the insurer.

GIO General Limited (ABN 22 002 861 583)

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