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

WorkCover QUEENSLAND

WorkSafe

# WORKER'S INJURY CLAIM FORM

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

[ ] New South Wales [ ] Queensland [X] Victoria

## 1 WORKER'S PERSONAL DETAILS

Title: Mr Family Name: Clarke

Given names: Mike

Other known or previous legal names *eg. Maiden name*: N/A

Date of birth: 3 / 7 / 68 Gender: [X] Male [ ] Female

Residential street address: 47 Smith Street

Suburb: Caroline Springs

State: Victoria Postcode: 3023

Postal address for correspondence: As above

What are your daytime contact phone number/s?

M 0412 345 678 W 4444 8765 H 9789 3456

E-mail address:

If you need an interpreter, what language do you speak? N/A

Do you have special communication needs because of disability? *eg. Hearing or vision impairment*: N/A

** 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?

Lower back strain

What happened and how were you injured?

Lifting heavy box of stock from floor to bench. Felt sudden strain in back.

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

Restocking of products

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

Warehouse

What is the street address where the incident occurred?

23 Brunton Avenue

Suburb: Derrimut

State: Victoria

Name of employer responsible for this workplace: ACB Logistics

Which of the following incident circumstances apply?

- [X] *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: N/A

Registration number/s of involved vehicles: N/A 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*

~~What was the date and time the injury/condition occurred?~~ ~~/ / / / 10 10:15 AM PM~~

~~When did you first notice the injury/condition?~~ ~~/ / / / 10~~

*Injured over the course of my employment.*

~~If you stopped work, what was the date and time?~~ ~~/ / / / 10 10:15 AM PM~~

~~When did you report the injury/condition to your employer?~~ ~~/ / / / 10~~

What is the name and position of the person you reported the injury/condition to?

Mr I Sutcliffe - First Aid Officer

If you did not report the injury/condition, or there was a delay, please explain why

N/A

What are the names and daytime contact details of anyone who witnessed the incident?

Mr Brad Weston
0434 567 321

Have you previously had another injury/condition or personal injury claim that relates to this injury/condition? *Please give details, including claim numbers*

No

If your injury did not occur on a particular date, do not feel compelled to nominate a date and time. It is acceptable to hand write "injured over the course of my employment".

You should ensure that you list **all** the injuries or illnesses related to your claim.

## 3 WORKER'S EMPLOYMENT DETAILS

Name of organisation paying your wages when you were injured: ACB Logistics

Street address of your usual workplace: 23 Brunton Avenue

Suburb: Derrimut

State: Victoria    Postcode: 3030

Name and daytime contact number of employer contact
*eg. Name of return to work coordinator*
Mr I Sutcliffe
0499 888 777

What is your usual occupation? *What do you do?* Storeman/Delivery driver

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

- [X] *Full-Time*
- [ ] *Part-Time*
- [ ] *Casual*
- [ ] *Student*
- [ ] *Apprentice*
- [ ] *Volunteer*
- [ ] *Contract*
- [ ] *Trainee*
- [ ] *Agency worker*
- [ ] *Contractor*
- [ ] *Permanent*
- [ ] *Temporary*
- [ ] *Seasonal*
- [ ] *Jockey*

*Other?*

When did you start working for this employer? 4 / 6 / 09

Please indicate if any of the following apply to you:

| Yes | No | |
|---|---|---|
| [ ] | [X] | *A Director of my employer's company* |
| [ ] | [X] | *A Partner in my employer's company* |
| [ ] | [X] | *A sole trader* |
| [ ] | [X] | *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* 38 hrs

What were your usual working hours?
*For example, Monday to Friday, 8.30 am to 5.30 pm*
Monday - Friday 8.00am to 4.30pm

What was your usual pre-tax hourly rate?* *Exclude overtime & shift allowances* $22.00

What were your usual pre-tax weekly earnings?* *Exclude overtime & shift allowances* $836.00

** 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

Dr Yang
Caroline Springs Medical Centre
Ph: 9449 0000

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*
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?
No

When did/will you give your employer this claim form? 2 / 1 / 10

How did/will you give this claim form to your employer?
- [X] *Hand delivery*
- [ ] *By post*

When did/will you give your employer the first medical certificate? 2 / 1 / 10

## 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 service 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: (signature)    Date: 2 / 1 / 10

** 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? 2 / 1 / 10

When did the employer first receive the worker's medical certificate? 2 / 1 / 10

**This question is required for Victorian claims*
Date claim form forwarded to Agent: 2 / 1 / 10

Estimated cost of claim to date: $ 270.00

How many days have been lost? 2 days hrs

Employer's signature: (signature)    Date: 2 / 1 / 10

Name: Mr Ivor Sutcliffe

Position: Return to Work Co-ordinator

Employer's scheme registration number
*eg. WorkCover Employer, Policy, or Employer Registration Number*
8336121

**ORIGINAL**

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If you choose to post the claim form to your employer, we recommend sending it via registered post to ensure your employer has received it.

Do not worry if you do not have all the information about your earnings. The WorkSafe Agent will obtain the details from your employer.

You must sign and date the document. The claim form cannot be accepted without both signatures.