VICTORIAN WORKCOVER AUTHORITY

WORKER'S INJURY CLAIM FORM

FOR HELP COMPLETING THIS FORM OR FOR MORE INFORMATION CONTACT:

- Your employer or the nominated Return to Work Coordinator at your workplace
- Your employer's WorkCover Agent - to find out who the Agent is check the *If you are injured* poster or call the WorkCover Advisory Service: freecall 1800 136 089 or (03) 9641 1444
- WorkCover Advisory Service - the VWA call centre: freecall 1800 136 089 or (03) 9641 1444
- WorkCover Assist - a free VWA service: (03) 9941 0537
- Your union
- Union Assist - a free service set up and run by the Victorian Trades Hall Council: (03) 9639 6144

AS THE WORKER YOU NEED TO:

3 Answer all of the questions on this form. The form may be returned to you if it is incomplete

3 Sign the authority to release medical information and worker's declaration at the end of this form. The form cannot be accepted without your signature

3 Read the statement on the back of this form that explains how your personal and health information will be collected and used

3 Keep a copy of all documents for your records

3 Notify your employer as soon as possible that you've been injured at work, and complete the injury register at your workplace. You can also notify the Agent directly by sending them the "early notification" copy of this form

3 Report the accident to the police if your injury was the result of a motor vehicle accident. Otherwise your claim may not be valid

3 Give this form (when completed) to your employer as soon as possible after being injured. If you have difficulty giving this claim to your employer, or your employer refuses to take receipt of the claim form, you can send it directly to the Agent or the VWA if the Agent is not known

3 See your medical practitioner to obtain a *WorkCover Certificate of Capacity (medical certificate)* if you are unable to work and want to claim weekly payments, and give the original copy to your employer along with this form. It is a good idea to check that all of the injuries or illnesses that you are claiming for on this form are listed on the *WorkCover Certificate of Capacity.*

GETTING BACK TO WORK

- **Talk with your employer to develop a return to work plan as soon as you are aware that you will be incapacitated for more than 20 days**
- **Talk to your medical practitioner about your limitations and what parts of your work you could do. You can also encourage your medical practitioner to talk to your employer about aspects of your work you could do and any suitable duties that may be available**
- **Talk to the Agent about what support is available to help you return to work and overcome your injury as quickly as possible**

YOUR EMPLOYER'S RESPONSIBILITIES:

- To confirm to you in writing that you notified them of this claim (They can also do this by giving you a copy of this form when signed and completed)
- If you are claiming weekly payments, they must send the completed form and any *WorkCover Certificates of Capacity (medical certificates)* to the Agent as soon as possible, but no later than 10 days after receiving them from you - or they may be financially penalised
- To pay you weekly payments if your claim is accepted and you have an entitlement
- To work with you to develop a return to work plan (if required), and, when you have a capacity to work, to include an offer of suitable employment
- To appoint a return to work coordinator to support your return to work if you are incapacitated for more than 20 days

Please note that there are penalties for providing false or misleading information in relation to this claim

The WorkCover Agent will write to you and advise you if your claim is accepted

A decision to accept or reject your claim will usually be made within 28 days (if you are claiming weekly payments), or 60 days (if the claim is for medical and like only expenses from the time the claim is received from the Agent)

To find out more about making a claim, and what support is available to help you return to work, talk to the Agent, refer to the brochure *Introducing WorkCover, a guide for injured workers*, or visit the website at ***www.worksafe.vic.gov.au***

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

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WORKER'S INJURY CLAIM FORM

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

☐ *New South Wales* ☐ *Queensland* ☐ *Victoria*

1 WORKER'S PERSONAL DETAILS

Title | Family Name

Given names

Other known or previous legal names *eg. Maiden name*

Date of birth / / | Gender ☐ Male ☐ Female

Residential street address

Suburb

State | Postcode

Postal address for correspondence

What are your daytime contact phone number/s?

M | W | 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?

What happened and how were you injured?

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

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

What is the street address where the incident occurred?

Suburb

State

Name of employer responsible for this workplace

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*

What was the date and time the injury/condition occurred?

/ / AM PM

When did you first notice the injury/condition?

/ /

If you stopped work, what was the date and time?

/ / AM PM

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

/ /

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

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

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

Have you previously had another injury/condition or personal injury claim that relates to this injury/condition?

Please give details, including claim numbers

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)

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

Other?

When did you start working for this employer?
/ /

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*

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 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 | 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

ORIGINAL

ACCIDENT COMPENSATION ACT 1985

WORKER'S INJURY CLAIM FORM

COLLECTION OF PERSONAL AND HEALTH INFORMATION TO MANAGE YOUR CLAIM*

In processing your claim, the Victorian WorkCover Authority (VWA) and any WorkCover Agent acting for the VWA in relation to your claim may collect personal and health information about you. The VWA and Agents are required by law to ensure that all people about whom they collect personal and health information are provided with the following information:

The VWA is a body corporate established under the Accident Compensation Act 1985. Agents are appointed by the VWA under that Act to act on its behalf in managing workers' compensation policies and claims for compensation.

Personal and health information about you is collected on this form and may also be collected during the processing, assessing and management of your claim. It may be collected from your current, previous and future employers, other government agencies, credit reporting agencies, health service providers and other persons who can provide information relevant to the claim.

Personal and health information about you also may be collected by solicitors, private investigators, loss adjusters and other service providers acting on behalf of the VWA or your employer's Agent.

Personal and health information collected about you is used for the purpose of processing, assessing and managing your claim and to verify any evidence you may submit in support of the claim. The information may also be used for one or more of the purposes listed in section 243 of the Accident Compensation Act 1985, for the purposes of legal proceedings arising under that Act, to assist with your rehabilitation and return to work and to assist the VWA and WorkCover Agents to better manage claims generally.

For the purposes of processing, assessing and managing your claim, the VWA and your employer's Agent may disclose personal and health information about you to each other and to the following types of organisations:

- employees, contractors and agents of the VWA and the VWA's Agents
- your employers
- solicitors, medical practitioners and other health service providers, private investigators, loss adjusters and other service providers acting on behalf of the VWA or the Agent in relation to the claim
- the Accident Compensation Conciliation Service and Medical Panels
- a court or tribunal in the course of criminal proceedings or any proceedings under any of the Acts which the VWA administers
- any other person, organisation or government agency authorised by you, or by law, to obtain the information.

Collection of this information may be required by the Accident Compensation Act 1985. If you do not provide any part or all of this information, your claim may not be accepted or processed.

You may request access to personal and health information about you collected by the VWA or your employer's Agent by contacting your employer's Agent.

The VWA's policies for managing personal and health information are set out in its Privacy Policy, which is available from your nearest VWA office or at **www.worksafe.vic.gov.au**. Information relating to your right to access your WorkCover claim information is also available at the website.

(*If your injury employer is an approved self-insurer, where you read 'VWA' and 'Agent' also read 'self-insurer' and 'approved agent of a self-insurer'.)