



Claim or notification number, if known

[] []

Policy number, if known

[] []

Agent for the NSW WorkCover Scheme

WORKERS COMPENSATION ACT 1987 INITIAL NOTIFICATION OF INJURY

This form is to be used when a worker suffers a workplace injury or illness where workers compensation is or may be payable. Notify your Agent within 48 hours. Notify injuries without delay, even if all the information is not known.

Please complete this form in BLOCK letters and use a black pen.

1 WORKER'S DETAILS

Family name

[] []

Given names

[] []

Date of birth

[D] [D] / [M] [M] / [Y] [Y]

Sex

[] Male [] Female

Residential address

Street

[] []

Suburb

[] []

Postcode

[] [] [] [] [] []

Phone

Work

Mobile

Home

() () ()

*Email

[] []

*Occupation

[] []

*Full time

[] []

*Part time

[] []

*Casual

[] []

2 EMPLOYER'S DETAILS

Company name

[] []

Location of business premises

Street

[] []

Suburb

[] []

Postcode

[] [] [] [] [] []

*Cost Centre

[] []

Name of workplace contact, if known (eg. name of return to work coordinator)

[] []

Phone

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3 INJURY DETAILS

Description of incident (eg. slipped from a ladder while painting the ceiling)

Description of injury (eg. concussion and broken right arm)

Date of injury

D	D	/	M	M	/	Y	Y
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***Average weekly earnings**

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***Weekly award / EBA / Award rate**

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Has the injured worker returned to work?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
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***Average Hours**

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If Yes, state date returned

D	D	/	M	M	/	Y	Y
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If No, estimate date of return

D	D	/	M	M	/	Y	Y
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4 EMPLOYMENT DETAILS

***Current capacity for work** ***Unfit** ***Suitable Duties, full hours** ***Suitable Duties, reduced hours** ***Pre injury Duties**

Tick applicable box

5 TREATING DOCTOR'S DETAILS

Doctor's name

Hospital name (if worker hospitalised)

Phone

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6 NOTIFIER'S DETAILS

Name

Relationship to worker or employer

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Address

Street

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Suburb

Postcode

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Phone

Work

Mobile

Home

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*This information will assist us to better manage your service needs