GallagherBassett VALID WORKER'S CLAIM FORM – EXAMPLE ONLY

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

WorkCover New South Wales · WorkCover Queensland · WorkSafe Victoria

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: MS Family Name: COOPER

Given names: ANGELA MARY

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

Date of birth: 28/09/79 Gender: ☐ Male ☑ Female

Residential street address: 15 JOHNSTON ST

Suburb: LYSTERFIELD

State: VIC Postcode: 3156

Postal address for correspondence: AS ABOVE

What are your daytime contact phone number/s? M 0411 333 800 W 9297 9000 H 9829 3015

E-mail address: amcooper@bigpond.com

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?

Strain to Right shoulder, arm back strain

What happened and how were you injured?

lifting a tray of food onto trolley, twisted around & bent down felt sharp pain to my shoulder & back

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

lifting tray of food

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

Resident's Room

What is the street address where the incident occurred?

15 Clarke St Upwey

Suburb

State: VIC

Name of employer responsible for this workplace: We Care Nursing Home

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: N/A

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

Example

A WorkCover claim which is the result of a motor vehicle accident must be reported to police.

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*

NO

What was the date and time the injury/condition occurred? 01/08/09 8.30 AM

A date of injury must be entered on the claim form. No date of injury will render the claim invalid.

When did you first notice the injury/condition? 01/08/09

If you stopped work, what was the date and time? 03/08/09 4.30 PM

When did you report the injury/condition to your employer? 01/08/09

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

ELAINE MCDONALD

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?

NO WITNESSES IN THE ROOM

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

Please give details, including claim numbers

NO

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3 WORKER'S EMPLOYMENT DETAILS

Name of organisation paying your wages when you were injured: WE CARE NURSING HOME

Street address of your usual workplace: 15 Clarke St

Suburb: UPWEY

State: VIC   Postcode: 3158

Name and daytime contact number of employer contact
eg. Name of return to work coordinator: ELAINE MCDONALD 9297 9026

What is your usual occupation? *What do you do?* KITCHEN HAND

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

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

Other?

When did you start working for this employer? 25/06/07

Please indicate if any of the following apply to you:

- [ ] Yes [x] No — A Director of my employer's company
- [ ] Yes [x] No — A Partner in my employer's company
- [ ] Yes [x] No — A sole trader
- [ ] Yes [x] 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*

CASUAL HAND IN CAFE ON MONDAYS & SATURDAYS

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* 18 hrs

What were your usual working hours?
For example, Monday to Friday, 8.30 am to 5.30 pm
TUES, THURS, FRIDAY 630 – 1230

What was your usual pre-tax hourly rate?* *Exclude overtime & shift allowances* $ 30.00

What were your usual pre-tax weekly earnings?* *Exclude overtime & shift allowances*
* *Please provide copies of any recent payslips (if available)* $ 540.00

Please provide details of any overtime or shift work

Weekly shift allowance $ N/A

Weekly overtime hrs $ N/A

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 ... of any medical providers (inclu... have treated your injury

DR PAUL F... 9795 11...

If you have returned to work with your employer, what was the date? / /   NO RTW

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?
WAITING ON CLEARANCE FROM DOCTOR

When did/will you give your employer this claim form? 02/09/09

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? 09/08/09

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 01/09/09

* *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 this 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? 02/09/09

When did the employer first receive the worker's medical certificate? 09/08/09

**This question is required for Victorian claims*
Date claim form forwarded to Agent 04/09/09

Estimated cost of claim to date $ 3,500

How many days have been lost? 16 days hrs

Employer's signature [signature]   Date 04/0...

Name: ANDREW MELFOT

Position: DIRECTOR OF HR

Employer's scheme registration number
eg. WorkCover Employer, Policy, or Employer Registration Number
1527981

Example

Claim form must be signed AND dated otherwise the claim is invalid.

You have 10 days to forward the claim to your Agent once *both* the claim form and certificate of capacity have been received.

Ensure these dates are accurate. They must reflect the day on which *both* forms were given to an employer representative for the first time.