Handy hints for *workers* completing the workers' compensation claim form

- Make sure you read the information surrounding the form so you understand how to make a claim, and the timeframes involved
- When filling in the form provide as much information as you can, and attach a separate sheet if you need extra space
- Remember the form is printed on carbon paper, press firmly with a pen on the front page so that it makes an exact copy on the second page
- Read through this fact sheet for a step by step explanation of completing the form

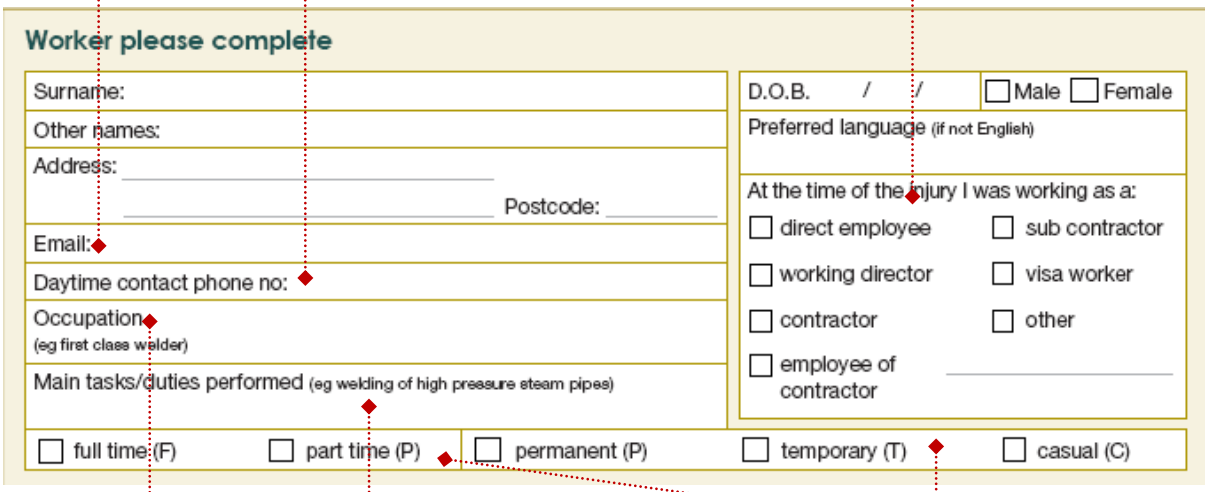
Completing the form

Provide a contact email address. Leave blank if you do not have one.

Include your mobile phone number here if that is the best number to contact you on.

This section asks you to nominate your conditions of employment at the time of the injury. Were you working as a direct employee, a working director, a sub contractor, contractor, a worker who is in Australia on a visa, or an employee of a contractor?

If none of these describe your conditions of employment, tick the 'other' box and write in the space provided.



Provide the name of your job here eg first class welder, hairdresser, administrative assistant.

Describe the main duties that you do in your job on a regular basis.

Make sure you tick this area in **two** places:

At the time of the injury:

- Were you a full time or part time employee, ***and***
- Were you employed on a permanent, temporary or casual basis.

Other Employment — If more than one employer, please attach details on separate sheet

Do you have any other job? ☐ Y ☐ N If yes, please give details:

Employer name: _____ Phone no: _____ Hours per week: _____

If you have a job other than the one you were injured in, you should list it here. This will allow the insurer to take into account all your income sources when calculating your weekly payments.

In this section you provide details of the circumstances relating to the injury.

By providing details of how and where your injury occurred, your employer and their insurer are able to deal with the claim quickly.

Occurrence details — Attach separate sheet if more space is required

Day of occurrence: eg Monday	Date of occurrence:	Time of occurrence: ☐ AM ☐ PM
At what address did the occurrence happen?		
Did you have to stop working? ☐ Y ☐ N	If so when? Date:	Time: ☐ AM ☐ PM

Were you:

- ☐ working – at your normal workplace
- ☐ on work break – at normal workplace
- ☐ working – away from normal workplace
- ☐ on work break – away from normal workplace
- ☐ working – road traffic accident
- ☐ commuting/journey
- ☐ other duty status

Describe the occurrence. Include:

(i) What action was involved (ie fall, struck by object)

(ii) What object/machine/substance was involved (ie fumes, door frame)

(iii) The most serious injury or disease caused (ie fracture, burn, abrasion)

(iv) The bodily location of the injury or disease (ie upper arm, eye)

WorkCover WA Staff Only
Mechanism
Agency
Nature
Bodily location

If you did not stop work straight away after the injury, indicate when you stopped work.

This is where you describe how the injury happened.

I. The 'action' describes how the injury occurred. For instance, it could be a fall, being struck by something, lifting an object or an electric shock.

II. The 'object/machine/substance' describes what was involved. For instance, if you were injured in a fall, what did you fall from? If you were hit by an object, what was the object?

II. Describe the most serious injury you have experienced in this incident, and

V. Which part of your body has been injured.

Important: If your claim does not involve a physical injury, for instance a stress claim you may choose to attach a separate sheet of paper to explain your circumstances.

This information will help the insurance company determine liability by outlining the details of where the injury occurred, who you reported it to and anyone who witnessed the incident.

If you were working alone at the time the injury occurred, just write that in the witness section.

Important: If you were working alone at the time of the injury, make sure you also use your company's incident reporting system or make a written note of the incident.

Worker please complete

Occurrence report – Describe how it happened — Attach separate sheet if more space is required

Where did the occurrence happen? (ie store room, machinery shop)
What were you doing at the time of the occurrence?
What were the normal working hours for that day? Starting time: ☐AM ☐PM Finish time: ☐AM ☐PM
When did you first report the occurrence? Date: Time: ☐AM ☐PM
Who did you report the occurrence to? Name: _____ Position: _____ Phone No: _____
If you didn't report the occurrence immediately, please state the reason if any:
Please provide the name and daytime contact phone number of witnesses of the occurrence: 1. Name: _____ Phone No: _____ 2. Name: _____ Phone No: _____

This is the section of the form where you provide information about the medical assistance you received for your injury.

You may not have been able to seek medical attention immediately, because you were on a remote site, or the injury occurred gradually.

State the date and time you *first* sought medical assistance and if this was not done immediately after the injury, briefly explain why.

Medical help/history – this occurrence — Attach separate sheet if more space is required

When did you first seek medical attention? Date: Time: ☐AM ☐PM If not immediately, please state the reason: _____
Was the part of the body affected by this occurrence healthy before this occurrence? ☐Y ☐N If not, please give details: _____
Is the present injury completely related to this occurrence? ☐ Y ☐ N If not, please give details:
Please give details of any similar injury prior to this occurrence: _____
Name and contact details of your usual medical practitioner and any health provider who has treated you for a similar injury: Name: _____ Address: _____ Phone no: _____

The insurance company needs to establish to what extent the injury you have sustained is related to your workplace incident.

This section explores whether you've had any similar injuries prior to this incident. They may be injuries you've sustained at work or away from the workplace.

If you are claiming compensation from any other source, list it here. For example, motor vehicle compensation. Also, include details of any related workers' compensation claims and the contact details of the employer and the insurer who you lodged the claim with.

Other / Previous claims — **Attach separate sheet if more space is required**

Are you claiming compensation from any other source? ☐ Y ☐ N If yes, from whom? _____

Have you had any similar or related workers' compensation claims? ☐ Y ☐ N If yes, please give details:

_____

Name of Employer: _____ Address: _____

Name of insurer (if known): _____ Type of injury or disease: _____

The worker's declaration asks for your signature in two places:

- The first signature declares that the information you have provided is correct and indicates you are aware of your obligations in making a claim.
- The second signature authorises the insurer to obtain information regarding your work related injury from any doctor treating you.

Important: If you do not sign both the declaration and the consent authority, you may be preventing or delaying acceptance of your claim. Make sure both your signatures are countersigned by a witness.

Worker's declaration

I solemnly and sincerely declare that each and every answer above and the particulars contained herein or annexed hereto relating to myself and the occurrence are true both in substance and in fact to the best of my knowledge and belief. I take notice that, under the provisions of section 59(2) of the *Workers' Compensation and Injury Management Act 1981*, I am required to notify my employer in writing within 7 days if I commence work with another employer after making a claim, or while receiving weekly payments of workers' compensation.

Dated this day of : Year:

Signature of worker _____ Signature of witness _____

Consent authority (to be signed at the option of the worker) I authorise any doctor who treats me (whether named in this certificate or not) to discuss my medical condition, in relation to my claim for workers' compensation and return to work options, with my employer and with their insurer.

Dated this day of : Year:

Signature of worker _____ Signature of witness _____

The insurance company often needs to speak to other parties to assess your workers' compensation claim.

By signing this consent authority you authorise the insurer to obtain and release relevant information regarding your work related injury.

Important: Not signing the consent authority may delay acceptance of your claim. Make sure that your signature is countersigned by a witness.

Consent authority – to be signed at the option of the worker

I consent to my employer's insurer and its appointed service providers collecting personal information, inclusive of sensitive information such as medical information about me and using it for the purpose of assessing and managing my workers' compensation claim, including determining liability and whether my claim is true. This consent extends to my employer's insurer disclosing my personal information, inclusive of sensitive information, to other insurers, medical practitioners, rehabilitation providers, investigators, legal practitioners and other experts or consultants for the purpose of assessing and managing my claim. My personal information, inclusive of sensitive information, may also be disclosed as required or permitted by law. I also consent to my employer's insurer disclosing my personal details to WorkCover WA which is authorised to use this information to fulfil its functions and obligations under the *Workers' Compensation and Injury Management Act 1981*. I have read all the information on this form regarding the consent authority and I consent to the Insurer dealing with my personal information in the manner described.

Signed _____ Witness signature _____

Print your name _____ Witness print name _____

Date Date