GOVERNMENT OF WESTERN AUSTRALIA

WorkCoverWA

Workers' Compensation Conciliation Service
2 Bedbrook Place
Shenton Park WA 6008
Ph 08 9388 5555
@WorkCoverWA
www.workcover.wa.gov.au

APPLICATION FOR CONCILIATION
Form 100

Office use only

NOTES FOR APPLICANT

- Complete this form to apply to have your dispute dealt with by the Workers' Compensation Conciliation Service.
- You are required to have made attempts to resolve the dispute before lodging this form.
- You may apply for conciliation online at https://online.workcover.wa.gov.au/
- Attach a separate page(s) to this form if you do not have enough space.
- This form **must** be signed.
- Once you have completed your application we advise that you keep a copy for your records.
- Completed forms can be lodged by either:

POST	IN PERSON	EMAIL
Workers' Compensation Conciliation Service, WorkCover WA, 2 Bedbrook Place, SHENTON PARK WA 6008	WorkCover WA, 2 Bedbrook Place, SHENTON PARK WA 6008 (Monday to Friday, 8am to 5pm)	Documents may be lodged by email subject to conditions. See the WorkCover WA website.

For further information or assistance in completing this form, please contact WorkCover WA's Advice and Assistance Unit on 1300 794 744 or (08) 9388 5537 (TTY).

SECTION A - APPLICATION DETAILS

1. Applicant
(party who is making application, e.g. worker's name)

2. Respondent
(party who application is against, e.g. employer's name)

The Applicant is the *(tick relevant box)*

- ☐ Worker
- ☐ Employer
- ☐ Insurer
- ☐ Other *(please specify)*

The Respondent is the *(tick relevant box)*

- ☐ Worker
- ☐ Employer
- ☐ Insurer
- ☐ Other *(please specify)*

(Note: Form 105 to be completed if there are multiple respondents)

3. Lodged by *(tick relevant box)*

- ☐ Worker
- ☐ Employer
- ☐ Insurer
- ☐ Dependant
- ☐ Worker representative
- ☐ Employer representative
- ☐ Insurer representative
- ☐ Service provider
- ☐ Other *(please specify)*

4. All notices from the Workers' Compensation Conciliation Service are sent by mail. Indicate if the applicant's preference is to receive notices by email.

☐ Email

SECTION B - INJURY AND CLAIM DETAILS

5. Date or period within which the injury or injuries occurred

6. What is the injury or injuries?

7. How did the injury or injuries occur?

8. Date the Workers' Compensation Claim Form was given to the employer

9. Workers' compensation claim number *(if known)*

SECTION C - DISPUTE DETAILS AND OUTCOME SOUGHT

10. Identify what type of dispute this application relates to by ticking the relevant box(es)

- ☐ Determination of liability (i.e. acceptance of claim)
- ☐ Non-payment of weekly compensation (i.e. wages)
- ☐ Non-payment of medical and other expenses
- ☐ Increase or reduce weekly payments
- ☐ Discontinue or suspend weekly payments
- ☐ Response to notice to discontinue weekly payments
- ☐ Extension of prescribed amount for weekly payments and/ or medical and other expenses *(Attach Form 101)*
- ☐ Level of permanent impairment
- ☐ Requirement of worker to undertake vocational rehabilitation
- ☐ Compensation for dependants following the death of a worker
- ☐ Other *(please specify)*

11. What is the outcome you are seeking from the dispute(s) identified above in question 10?

SECTION D - ATTEMPTS TO RESOLVE DISPUTE

This section must be completed.

12. What attempts have been made to resolve the dispute? *(Include the dates of any communication, the names of the people or parties involved and any action taken to resolve the dispute prior to lodging this application)*

SECTION E - PARTY DETAILS

13. Worker details

Title (Mr/Mrs/ Ms/Miss/Dr)		Given names		Surname	
Male/Female		Date of birth		Occupation	
Postal address					
City/Suburb			State		Postcode
Phone		Fax		Mobile	
Email					
Interpreter required? (Yes/No)		Language/dialect			

14. Worker representative's details *(if represented by a legal practitioner or registered agent - complete if known)*

Company name					
Contact person			Reference *(if known)*		
Phone		Fax		Mobile	
Email					

15. Employer details

Employer name					
Contact person					
Postal address					
City/Suburb			State		Postcode
Phone		Fax		Mobile	
Email					

16. Employer representative's details *(if represented by a legal practitioner or registered agent - complete if known)*

Company name					
Contact person			Reference *(if known)*		
Phone		Fax		Mobile	
Email					

17. Insurer/self insurer details

Company name					
Contact person			Reference *(if known)*		
Phone		Fax		Mobile	
Email					

18. Insurer/self insurer representative's details *(if represented by a legal practitioner or registered agent - complete if known)*

Company name					
Contact person			Reference *(if known)*		
Phone		Fax		Mobile	
Email					

SECTION E - PARTY DETAILS *continued*

19. Dependant details *(only to be completed when compensation is sought by dependants following the death of a worker)*

Title (Mr/Mrs/ Ms/Miss/Dr)		Given names		Surname	
Male/Female		Date of birth		Occupation	
Postal address					
City/Suburb		State		Postcode	
Phone		Fax		Mobile	
Email					
Interpreter required? (Yes/No)		Language/dialect			

19a. List of dependants *(only to be completed when compensation is sought by dependants following the death of a worker)*

Name	Date of birth	Relationship to worker	Wholly/partially dependant

20. Other party details

Company name					
Contact person					
Postal address					
City/Suburb		State		Postcode	
Phone		Fax		Mobile	
Email					

21. Dependant/Other party representative's details *(if represented by a legal practitioner or registered agent - complete if known)*

Company name					
Contact person		Reference *(if known)*			
Phone		Fax		Mobile	
Email					

SECTION F - SUPPORTING DOCUMENTS

I have attached documents supporting the application ☐ Yes

(Documents may include, for example, the Workers' Compensation Claim Form, copies of medical certificates and reports, correspondence between parties, personal statements, witness statements, vouchers/accounts/receipts which apply to expenses claimed etc)

SECTION G - SIGNATURE OF APPLICANT

Signature

Name

Date