GOVERNMENT OF WESTERN AUSTRALIA

WorkCoverWA

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

APPLICATION FOR ARBITRATION
Form 150

Office use only

NOTES FOR APPLICANT

- Complete this form to apply to have your dispute dealt with by the Workers' Compensation Arbitration Service.
- An Application for Arbitration can only be made where a Conciliation Officer has issued a Certificate of Outcome (s182O) or the Director of the Conciliation Service has issued a Certificate stating the dispute is not suitable for conciliation (s182H).
- You must apply within 28 days of the issue of either certificate. If there are extenuating circumstances, you may request an extension of time to lodge an application by completing an Application to Extend Time to Make an Application for Arbitration Form (Form 152) instead.
- You may lodge an Application for Arbitration online at https://online.workcover.wa.gov.au instead of using this form.
- Attach a separate page(s) to this form if you do not have enough space.
- This form **must** be signed.
- Completed forms can be lodged by either:

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

- If lodging by post or in person, you must file the original application and attachments with the Workers' Compensation Arbitration Service, plus a copy for each party to the dispute.
- Sealed copies will be returned to you for service on the other parties.

NOTES FOR RESPONDENT

- A reply to this application outlining the grounds of dispute which are admitted and/or disputed, along with all supporting documents must be lodged within 14 days of the date of service of this application unless the time is abridged or extended by order of an Arbitrator or the Registrar.

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)*

(Note: Form 161 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 Arbitration Service are sent to EDA (online) exempt parties by mail. Indicate if the applicant's preference is to receive notices by email. ☐ Email

SECTION B - INJURY AND CLAIM DETAILS

Do not complete this section if the claim is solely for a stress related psychological injury or recurrence, aggravation or acceleration thereof

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

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

7. Workers' compensation claim number

8. State the nature of the injury or injuries

9. Describe the circumstances in which the injury or injuries occurred

SECTION C - STRESS CLAIMS

Complete only questions 10 - 14 for stress claims involving the contraction of a psychological injury

10. State the nature of the psychological injury

11. Date or period within which the psychological injury was contracted

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

13. Workers' compensation claim number

14. Describe, in summary form, the acts, events or circumstances of the employment which contributed to the contraction of the psychological injury

Complete only questions 15 - 19 for stress claims involving the recurrence, aggravation or acceleration of a pre-existing psychological injury

15. State the nature of the pre-existing psychological injury

16. Date or period within which the pre-existing psychological injury recurred, was aggravated or was accelerated

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

18. Workers' compensation claim number

19. Describe, in summary form, the acts, events or circumstances of the employment which significantly contributed to the recurrence, aggravation or acceleration of the pre-existing psychological injury

SECTION D - APPLICANT'S CLAIM

Please complete whichever of questions 20 - 24 apply to the above issues

Worker's application for weekly payments

20. The Applicant is claiming for

20.1 Period/s for which payments are sought

20.2 Increase of payments from

State the reasons an increase is sought

20.3 Determination of amount of compensation

Current amount *(if applicable)* *(per week gross)* Amount sought *(per week gross)*

20.4 Payments beyond prescribed amount for permanent total incapacity

Date from which payments sought

☐ Copy of Statement of Social and Financial Circumstances (Form 153) is attached

20.5 Was a Notice advising of intention to reduce or cease payments received? ☐ Yes ☐ No

If 'Yes' when was the Notice received?

☐ Copy of the Notice to Worker of Intention to Discontinue or Reduce Payments (Form 5) is attached

Worker's application for statutory expenses

21. The Applicant is claiming for

21.1 ☐ Medical/hospital/other expenses *(provide specific details below)*

Date	Nature of expense	Name of Provider	Amount
(dd/mm/yyyy)			$
(dd/mm/yyyy)			$
(dd/mm/yyyy)			$

21.2 ☐ Extension of prescribed amount

☐ Copy of Statement of Social and Financial Circumstances (Form 153) is attached

Employer's application for reduction or discontinuance of weekly payments

22. The Employer is claiming for

22.1 Reduction sought from $ *(present gross per week)* to $ *(gross per week)* from (dd/mm/yyyy)

22.2 Discontinuance from

State the reasons for reduction or discontinuance

Dependancy ***(complete only if claiming compensation after death of the worker)***
Note: If the worker's death occurred on or after 1 July 2018, complete a Form 150A.

23. List dependants

Name	Date of birth	Relationship to worker	Wholly/partially dependant
	(dd/mm/yyyy)		
	(dd/mm/yyyy)		
	(dd/mm/yyyy)		

23.1 Specify the Schedule 1 clause under which compensation is claimed

Other ***(for example, disputes as to degree of permanent impairment or rehabilitation or recovery of payments)***

24. Specify the nature of the dispute and the orders sought

SECTION E - ISSUES IN DISPUTE

25. These proceedings were not resolved by conciliation. Attached is either *(tick relevant box)*

☐ A copy of the Certificate of Outcome (s182O) ***OR*** ☐ A copy of the Certificate of Unsuitability (s182H)

26. Issues remaining in dispute following the Application for Conciliation which require arbitration are

27. Additional issues NOT included in the Application for Conciliation are
(The Arbitrator will advise whether these issues will be included in the scope of the arbitration of this application)

SECTION F - SUPPORTING DOCUMENTS AND INFORMATION

28. List documents and information attached to this application

Medical documents	Author/Doctor	Speciality *(e.g. Orthopaedic)*	Date of document
			(dd/mm/yyyy)
			(dd/mm/yyyy)
			(dd/mm/yyyy)
			(dd/mm/yyyy)
			(dd/mm/yyyy)
			(dd/mm/yyyy)
			(dd/mm/yyyy)

Non-medical documents	Author	Date of document
		(dd/mm/yyyy)
		(dd/mm/yyyy)
		(dd/mm/yyyy)
		(dd/mm/yyyy)
		(dd/mm/yyyy)
		(dd/mm/yyyy)
		(dd/mm/yyyy)

29. List documents and information you intend to use but do not yet have *(not applicable for applications under section 60, 62, 71 or 72A)*

Medical

Nature of Evidence	Author/Doctor	Speciality	Reason not available	Date of expected availability
				(dd/mm/yyyy)
				(dd/mm/yyyy)
				(dd/mm/yyyy)
				(dd/mm/yyyy)
				(dd/mm/yyyy)
				(dd/mm/yyyy)
				(dd/mm/yyyy)

Non-medical

Nature of Evidence	Author	Intended use	Reason not available	Date of expected availability
				(dd/mm/yyyy)
				(dd/mm/yyyy)
				(dd/mm/yyyy)
				(dd/mm/yyyy)
				(dd/mm/yyyy)
				(dd/mm/yyyy)
				(dd/mm/yyyy)

SECTION G - PARTY DETAILS

30. 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			

31. 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				

32. Employer details

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

33. 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				

34. Insurer/self insurer details

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

35. 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 G - PARTY DETAILS *continued*

36. Other party details *(if other parties are involved in the dispute)*

(Tick relevant box) ☐ Service provider ☐ Dependant ☐ Other *(please specify)*

Company name					
Contact person					
Postal address					
City/Suburb		State		Postcode	
Phone		Fax		Mobile	
Email					
Interpreter required? (Yes/No)		Language/dialect			

37. Other party representative's details *(if represented by a legal practitioner or registered agent)*

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

SECTION H - SIGNATURE OF APPLICANT

Signature

	Name	
	Date	