Workers Compensation and Injury Management Act 2023

custody Or Imprisonment notice

## PART 1

To be completed by the employer and/ or the employer’s insurer and provided to the CEO Prisons or authorised officer.

## Worker

|  |  |
| --- | --- |
| Name: |   |
| Address: |   |
| Date of birth: |   |

## Employer

|  |  |
| --- | --- |
| Name: |   |
| Address: |   |
| ABN: |   |
| Nominated contact person:  |   |
| Email: |   |

## Insurer

|  |  |
| --- | --- |
| Insurer: |   |
| Insurer claim number: |   |
| Date worker’s income compensation commenced: |   |

**Note**: Please ensure the liability decision notice issued by the insurer or self-insurer is attached with this notice as evidence of a compensable claim and the connection between the worker, employer and insurer.

## CONFIRMATION OF CUSTODY OR IMPRISONMENT

The *Workers Compensation and Injury Management Act 2023* (the Act) requires payment of income compensation **must** be suspended for the period a worker is in custody or otherwise serving a term of imprisonment, and that the Chief Executive Officer (Prisons) or Registrar of the Mental Impairment Review Tribunal **must** provide written confirmation of the worker’s custody or imprisonment status. Regulations require the confirmation to be given to the worker’s employer.

Before payments of income compensation can be suspended the employer named in this notice requires you to confirm the worker is in custody or serving a term of imprisonment by completing Part 2 of this notice and returning the notice to the employer’s nominated contact and email address above.

## PART 2

To be completed by the CEO Prisons or authorised officer and provided to the worker’s employer via the employer’s nominated contact and return email address noted above.

## Confirmation by Authority

|  |  |
| --- | --- |
| Authority: | [ ]  CEO Prisons  |
| Worker: |   |
| Is or was the worker in custody1: | [ ]  Yes [ ]  No |
| If yes, date the worker was taken into custody: |   |
| Is the worker still in custody: | [ ]  Yes [ ]  No |
| If no, date of release: |   |

If unable to confirm, please provide reasons:

|  |
| --- |
|   |

|  |  |
| --- | --- |
| Signed: |   |
| Date: |   |
| Name: |   |
| Phone: |   |
| Email: |   |

1. This is referring to any period that the worker was receiving income compensation. Refer to date worker’s income compensation commenced under ‘Insurer details’.