

# WORKERS COMPENSATION EMPLOYER'S REPORT FORM

**It is essential that this form be completed to enable the worker's entitlement to compensation to be promptly determined. PAYMENTS SHOULD NOT BE COMMENCED UNTIL AUTHORISED BY US.**

If claiming for medical expenses and no time has been lost, complete all questions except questions 15. Please use "BLOCK" capitals.

Policy no.

Primary Risk Code (if applicable)

Secondary Risk Code (if applicable)

## 1. Employer details

Full name of employer

Trading name of employer

Type of Business

Address

Postcode

Business telephone no.

Facsimile no.

Contact name

Email

ABN

## 2. Injured worker

Surname

Given name(s)

Address

Postcode

Private/mobile telephone no.

Worker's occupation

Age

DOB

/

/

Married? No

Yes

Relationship (if any) to employer

## 3. Accident

Date of accident

/

/

Time

Day of week

How long had the worker worked, on the date of the accident, before the injury?

hrs

mins

Date work ceased

/

/

Time

Date first Medical Certificate received by employer

/

/

at

Date claim form received from worker

/

/

at

Was the worker affected by alcohol or drugs?

No

Yes

#### 4. Nature of injury

Report the 'Type of injury' (e.g. fracture, sprain, amputation, etc.) and under 'Part of body' report, as precisely as possible, the part of the body injured. Where multiple injuries are received, report 'Type of injury' the nature and 'Part of body' of each injury and, where known, indicate which injury is the most severe.

Type of injury (e.g. laceration, sprain, etc.)	Part of body (e.g. head, lower back, etc.)	Side of body (e.g. left/right)
1.		
2.		
3.		

#### 5. Result of injury

Enter the result as known at the time of completing this report. '**Totally unfit**' relates to claims where the worker is considered to be totally incapacitated for any type of work. '**Partially unfit**' relates to claims where the worker is fit to undertake restricted duties either on a part time or full time basis.

Please tick (✓) in the appropriate box. Fatal ☐ Partially unfit ☐ Totally unfit ☐ No time lost ☐

Has the worker resumed work? Yes ☐ Date  /  /

No ☐ Estimated period of incapacity Weeks  Days

Have you any other duties which the worker could perform until he/she can resume his/her pre-injury duties?

No ☐ Yes ☐ Please provide details

#### 6. Cause of accident

Indicate with a tick (✓) the occurrence that gave rise to the accident.

- |   |                          |   |                          |
|---|--------------------------|---|--------------------------|
| e. Undertaking normal duties – Normal Workplace       | <input type="checkbox"/> | f. Undertaking normal duties – Not normal workplace       | <input type="checkbox"/> |
| g. Undertaking normal duties – Road Traffic Accident  | <input type="checkbox"/> | h. Commuting/Journey                                      | <input type="checkbox"/> |
| i. During meal or other work break – Normal Workplace | <input type="checkbox"/> | j. During meal or other work break – Not Normal Workplace | <input type="checkbox"/> |
| k. Other Duty – please specify                        |                          |   |                          |

#### 7. Address where accident took place

Address  Postcode

Was worker working at your premises or elsewhere? If working elsewhere, please provide full details of the occupier/owner of the premises where they were injured.

#### 8. Department/section where worker was employed (e.g. welding shop)

#### 9. State the actual process in which the worker was engaged at the time of accident (e.g. cleaning machinery, ploughing, etc.)

#### 10. Describe concisely all the circumstances of the accident and ensure that the type of accident and the agency causing it are detailed

**Type of accident** - is the manner in which the injury occurred (e.g. fall, struck by falling object, caught in or between objects, contact with harmful substances, etc.)

**Agency** - refers to the working environment (machine, means of transport, substance, etc. causing the accident, e.g. conveyor failed.)

### 11. Please indicate whether

a. any machinery/equipment was involved in the accident?

If **Yes**, please identify the machinery: please provide a full and precise description of the machinery/equipment and who owned the machinery/equipment?

b. there was any breach of any statutory or other regulations at the time of injury.

If **Yes**, please provide details

c. there was any serious and wilful misconduct on the part of the worker which contributed to the injury.

If **Yes**, please provide details

d. the injury was caused by the negligence of any person.

If **Yes**, give details

No Yes

### 12. Reporting of accident

Name of person to whom the accident was reported

Date reported

Time

Occupation

### 13. Witness/Co-worker details

Name of witness/co-worker

Employed by

Address of witness/co-worker

Postcode

Occupation

If more than one witness, please attach a list on a separate page.

### 14. Employment details

Date first employed

Indicate with a tick (✓) the days usually worked each week.

Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday ☐

State standard number of hours worked:

Per day

Per week

Is this worker subject to a VISA?

No

Yes

What type of visa? e.g. S457

1. Was the worker directly employed? (i.e. not a contractor or employee of a contractor)

Yes

No

Please provide details

2. Which of the following covers the status of the worker's employment?

Full time	<input type="checkbox"/>	No. of hours per week	<input type="text"/>
Part time	<input type="checkbox"/>	No. of hours per week	<input type="text"/>
Casual	<input type="checkbox"/>	The number of weeks he/she has worked for you over the past year	<input type="text"/>
Seasonal	<input type="checkbox"/>	Length of season in weeks over 12 month period	<input type="text"/>

## 15. Worker's earnings

To enable us to calculate this worker's weekly compensation rate please provide details of their past earnings.

For award workers we require 13 weeks past earnings before the date of incapacity. If employed less than 13 weeks, we only require the past earnings over the period of employment with you. You will also need to complete the details of the Award or Agreement requested below.

For non-award workers we require 12 months past earnings before the date of injury including all bonuses and allowances. If employed for less than 12 months, we only require the past earnings over their period of employment including the number of weeks employed by you.

### Award

Period	Gross Amount
Week 1	\$
Week 2	\$
Week 3	\$
Week 4	\$
Week 5	\$
Week 6	\$
Week 7	\$
Week 8	\$
Week 9	\$
Week 10	\$
Week 11	\$
Week 12	\$
Week 13	\$

### Non Award

Period	Gross Amount
Month 1	\$
Month 2	\$
Month 3	\$
Month 4	\$
Month 5	\$
Month 6	\$
Month 7	\$
Month 8	\$
Month 9	\$
Month 10	\$
Month 11	\$
Month 12	\$

### Award or Enterprise Agreement

Name of Award or Enterprise Agreement

Base Award Rate and Hours

Over award amount paid on a regular basis (excluding allowances)

Shift Allowance

Bonus

Casual Allowance

Other Allowances (otherwise not specified)


### DO YOU AGREE WITH THE DETAILS OF THE OCCURRENCE AS PROVIDED ON THE WORKERS' COMPENSATION CLAIM FORM?

Yes ☐ No ☐ Please provide details

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Signature of the employer

Date

Official Position

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D	D	/	M	M	/	Y	Y
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**NOTE: THIS FORM IS TO BE SIGNED BY A PERSON (OTHER THAN THE INJURED WORKER) AUTHORISED BY THE EMPLOYER**