

INJURED WORKER'S REPORT**About You**

1 Surname

Mr/Mrs/Miss/Ms

2 First/Other Names

3 Address

Postcode:

4 Telephone No

W ()

H ()

5 Date of Birth

//_/

6 Sex

Male ☐Female ☐

7 Where were you born?

Australia ☐Overseas ☐If 'overseas' print
country of birth

Office use

8 Do you speak a language other
than English at home?No ☐Yes ☐If 'yes' print
language spoken

Office use

About Your Condition9 Date and time the injury or condition
occurred, first noticed or identified

//_/

am/pm

10 Describe how the injury or condition occurred

(i) Give the details of what happened, how it
happened and what was involved, e.g. knocked
off ladder by tractor and tractor ran over legs; inhaling
asbestos fibres when demolishing old buildings

Office use

Mech

Agency of Injury

B/dwn Agency
of Injury(ii) What was/were the most serious type(s) of
injury or disease caused by this occurrence?
e.g. burn; cut; fracture; hernia

Injury

(iii) What part of the body was most seriously
affected by this occurrence?
e.g. upper arm; left ankle; right eye; upper back

POB

**You must attach a Workers Compensation Medical Certificate to
this claim.**

11 Where did your injury or disease occur?

Print town, suburb or locality

Postcode

Office use
ASGC

12 Date and time you stopped work

//_/

am/pm

13 Date and time you started work
on the day or shift of the accident

//_/

am/pm

14 When did your injury or disease occur?

At work—working at normal workplace ☐At work—road traffic accident ☐At work—on authorised break ☐At work—working away from normal workplace ☐Away from work during recess period ☐Travelling to or from work ☐15 Is your injury or condition solely due
to this occurrence?No ☐Yes ☐16 Are there other causes of
your condition?No ☐Yes ☐

17 Name of treating doctor

18 Name of treating hospital

Worker's Medical Authority**NOTE: You do not have to complete this Authority.
However, not doing so may mean delays to your claim
being finalised.***To any medical practitioner or other person who has treated me, or the
Registrar of any hospital at which I have received treatment.*

I, employed by

*authorise any medical practitioner or any other person who has treated me or
the Registrar of any hospital at which I have received treatment to give my
employer, or his insurer, information about myself specific to this claim for
worker's compensation. A photocopy of this authority is to be considered as
valid as the original.*

19 Your signature

20 Date Signed

//_/

Notification and Witnesses

21 Name of person notified

22 Date and time notified

//_/

am/pm

23 Your supervisor's name

24 Name of any witnesses

25 Have you made

any claims before?

No ☐Yes ☐If yes, give
details below**Worker's Certification****The Workers Rehabilitation and Compensation Act 1988
imposes heavy penalties for giving false or misleading
information.***I declare that to the best of my knowledge and belief, all the information given
in this form is true and correct in every particular.*

26 Your signature

27 Date signed

//_/

28 Witness to signature

EMPLOYER'S REPORT

29 Employer's legal name, i.e. Registered Company Name, State Government Department, Partnership, Sole Trader's Name
e.g. J Citizen Pty Ltd, Department of Education

30 Australian Business Number (ABN)

31 Employer's address

Postcode:

32 Employer's trading name or Division in State Government Department, e.g. J Citizen's Laundromat, Primary Education

33 Employer's major business activity at the injured worker's workplace, e.g. dry cleaner, wholesale grocer, dental surgery

34 How many workers do you employ *head count:* **in Tasmania**, not just this workplace?

Rehabilitation Details

35 Does the worker's Medical Certificate indicate a need for rehabilitation? No ☐ Yes ☐

36 Can suitable duties be provided? No ☐ Yes ☐

37 What is the worker's estimated time off work?

No lost time ☐

Less than one day ☐

1 day to 2 weeks ☐

More than 2 weeks, less than 3 months ☐

More than 3 months ☐

Worker's Employment Details

38 Normal weekly earnings (See front page for explanation) \$

39 Ordinary time rate of pay per week (See front page for explanation) \$

40 Average hours usually worked per week (hrs) (mins)

41 Average days usually worked per week

42 Describe the worker's normal occupation

43 Department or section
e.g. dispatch, warehouse, sales

Office use

Office use

44 Date the worker started in your employment

45 Is the worker a:

Direct employee ☐

Contractor ☐

On commission ☐

Other ☐

If 'other' give details below, e.g. in training program, police volunteer, fire fighting/fire prevention operations, etc

46 Claim lodgement date

47 Date of next payday following the date of claim lodgement

Employer Contact Information

Please give the name of someone who can be contacted for additional information about this claim

48 Contact Name

49 Contact Phone ()

Employer Certification

The Workers Rehabilitation and Compensation law imposes heavy penalties for giving false or misleading information

I am satisfied that the information given on this form is true and correct ☐

I believe that further investigation into this claim is required ☐

50 Employer representative's signature

51 Date signed

52 Name of representative

53 Position

INSURER'S REPORT**Policy and Claim Details**

54 Insurer name

Office use
Insurer Number

55 Policy Number

56 ANZSIC classification of policy

57 Claim number

58 Claim type New ☐ Re-opened ☐ Aggravation ☐ Recurrence ☐ Other ☐

If reopened, tick one below

If 'other' give details below:

59 Date of claim receipt by insurer
(For self-insurers this date will be the same as shown in question 46)