7KH 5HWXUQ WR :RUN VFKHPH SURYLGHV WLPHO\ SHUVRQDOLVHG VXSSRUW DQG VHUYLFHV WR ZRUNHUV DQG WKHLU HPSOR\HUV

6RXWK $XVWUDOLDQV ZKR KDYH EHHQ LQMXUHG DW ZRUN PD\ EH HOLJLEOH IRU LQFRPH VXSSRUW DQG RU WKH UHLPEXUVHPHQW RI PHGLFDO H[SHQVHV DQG RWKHU UHWXUQ WR ZRUN VHUYLFHV

%HIRUH PDNLQJ D FODLP ZRUNHUV QHHG WR

1RWLI\ \RXU OLQH PDQDJHU RU VXSHUYLVRU DQG :HOOEHLQJ $GYLVRU\ DW WKH HDUOLHVW RSSRUWXQLW\

6HH D GRFWRU WR JHW D :RUN &DSDFLW\ &HUWLILFDWH

+RZ WR PDNH D FODLP

6WHS &RPSOHWH WKLV IRUP

:KHUHYHU SRVVLEOH \RXU GRFWRU DQG WKH HPSOR\HU VKRXOG FRPSOHWH WKLV IRUP WRJHWKHU $ UHSUHVHQWDWLYH VXFK DV D WUDGH XQLRQ RIILFLDO &RRUGLQDWRU FDQ SURYLGH DGYLFH DQG VXSSRUW

6WHS 6LJQ WKH 0HGLFDO $XWKRULW\ DQG GHWDFKDEOH SDJH

6WHS /RGJH WKLV IRUP DQG \RXU :RUN &DSDFLW\ &HUWLILFDWH

%\ VHQGLQJ WKLV IRUP WKURXJK WR

,QMXU\ 0DQDJHPHQW DQG :HOOEHLQJ $GYLVRU

81,9(56,7< 2) $'(/$,'(

+XPDQ 5HVRXUFHV

/HYHO 5XQGOH 0DLO ]D

$GHODLGH

RU

6FDQ ERWK GRFXPHQWV DQG HPDLO WKH ,QMXU\ 0DQDJHPHQW DQG :HOOEHLQJ $GYLVRU ORXLVH GXQQ#DGHODLGH HGX DX ZLWK FF WR WKH 0DQDJHU

+6: 3ROLF\ DQG ,QMXU\ 0DQDJHPHQW #DGHODLGH HGX DX

## PSRUWDQW LQIRUPDWLRQ IRU

! 5HSRUW D ZRUN LQMXU\ WR \RXU HPSO WDON WR WKHP DERXW D SODQ WR VW

! 7DON WR \RXU GRFWRU DERXW ZRUN W :RUN &DSDFLW\ &HUWLILFDWH

! %H DFWLYH\ LQYROYHG LQ \RXU WUH ZRUN RU VWD\ DW ZRUN SODQV

## ,PSRUWDQW LQIRUPDWLRQ IRU

! 7KLV IRUP PXVW EH VXEPLWWHG WR \R EXVLQHVV GD\V RI \RX UHFHLYLQJ LW

! 7KHUH DUH ILQDQFLDO LQFHQWLYHV IR FODLP IRUP WRJHWKHU ZLWK WKH :RUN EHHQ JLYHQ RQH ZLWKLQ ILYH FDOHQ IURP WKH ZRUNHU )RU PRUH LQIRUPDV ZZZ UWZVD FRP

! 1RWLILDEOH LQFLGHQWV

W LV D OHJDO UHTXLUHPHQW WKDW 6 IRU D SHUVRQ ZKR FRQGXFWV D E QRWLI\ 6DIH:RUN 6$ RI

‡ WKH GHDWK RI D SHUVRQ

‡ D VHULRXV LQMXU\ RU LOOQHVV RI D IRU DPSXWDWLRQ VHULRXV KHDG H\ VHSDUDWLRQ RI VNLQ IURP XQGHUO\L IXQFWLRQ PHGLFDO WUHDWPHQW ZL

‡ D GDQJHURXV LQFLGHQW WKDW H[SR VHULRXV ULVN WR D SHUVRQ¶V KHDO LPPHGLDWH RU LPPLQHQW H[SRVXUH DFWXDOO\ RFFXUUHG

3OHDVH QRWLI\ 6DIH:RUN 6$ E\ FDOOLQJ

)RU PRUH LQIRUPDWLRQ DERXW 6DIH:RUN ZZZ VDIHZRUN VD JRY DX

6HULRXV SHQDOWLHV FRXOG DUULVH LI

## Section 1 - About this claim

**1A - What is the claim for?**

☐ Loss of wages ☐ Medical expenses

☐ Loss of wages and medical expenses

**1B - Who is filling out this form?**

When possible, it is suggested the worker and employer complete this form together.

☐ Worker ☐ Employer

☐ Both worker and employer completing the form together

☐ Other - Name: _____

Relationship (i.e. Family, friend or representative): _____

_____

Phone _____

## Section 2 - Worker details

Family name: _____

Given names: _____

Former names (if any) _____

Title: ☐ Miss ☐ Ms ☐ Mrs ☐ Mr

Date of birth: ☐☐ / ☐☐ / ☐☐☐☐

Gender: ☐ M ☐ F ☐ Other

Address: _____

_____

Postal address (or if same write 'same as above') _____

_____

Daytime phone number: _____

Mobile number: _____

Email: _____

(Note: Providing an email will ensure prompt receipt of important notices.)

Does the worker wish to identify as:

☐ Aboriginal ☐ Torres Strait Islander

Country of birth: _____

Does the worker need an interpreter?: ☐ Yes ☐ No

If yes, identify language (including Auslan): _____

Dialect _____

Is the worker an Australian citizen or permanent resident of Australia?

☐ Yes ☐ No

If 'No' _____

Type of visa _____

Expiry date ☐☐ / ☐☐ / ☐☐☐☐

## Section 3 - Injury details

**3A - Injury information**

What was the circumstance in which the injury occurred?

(tick one) while:

☐ Working at usual workplace

☐ Working, had a traffic accident—Police Report Number:

☐ Having a break ☐☐☐☐☐☐☐☐

☐ Travelling to or from work

☐ Attending an approved course of study

☐ Working elsewhere

☐ Other (please specify): _____

Date and time of the injury: (or when was it first noticed)

Date ☐☐ / ☐☐ / ☐☐☐☐ Time ☐☐☐☐☐☐ am/pm

Did the worker stop work due to the injury? ☐ Yes ☐ No

If yes, date and time work was stopped:

Date ☐☐ / ☐☐ / ☐☐☐☐ Time ☐☐☐☐☐☐ am/pm

Has the worker resumed work? ☐ Yes ☐ No

If yes, date and time worker resumed:

Date ☐☐ / ☐☐ / ☐☐☐☐ Time ☐☐☐☐☐☐ am/pm

Has the worker returned to:

☐ pre-injury hours or ☐ less than pre-injury hours

Has the worker returned to:

☐ normal duties or ☐ modified duties

**3B - Where did the injury occur?**

Place (e.g. workshop floor) _____

Address: _____

Suburb / town: _____ Postcode: _____

**3C - Description of the injury**

What is the injury and part of the body affected? (e.g. broken left lower leg, dermatitis of the hands, lower back strain): _____

_____

_____

What was the worker doing at the time of the injury? (e.g. lifting bags of cement from pallet to trolley): _____

_____

_____

_____

What happened and how was worker injured? (e.g. repeatedly lifting heavy bags causing lower back pain): _____

_____

_____

_____

_____

## Section 4 - Capacity for work and treatment

### 4A - Treating doctor's information

Name: _____

Practice name: _____

Practice phone: _____

Practice address: _____

Suburb / town: _____ Postcode: _____

Hospital (if the worker was or is hospitalised) _____

### 4B - Work Capacity Certificate details

The worker's Work Capacity Certificate covers the period from:

☐☐ / ☐☐ / ☐☐☐☐ to ☐☐ / ☐☐ / ☐☐☐☐

## Section 5 - Employment details

### 5A - Employer's name and address

Full company or business name: _____

Trading name: _____

Postal address: _____

Suburb / town: _____ Postcode: _____

Phone: _____

Email: _____

(Note: Providing an email address will ensure prompt receipt of important notices)

ReturnToWorkSA employer number: _____

ReturnToWorkSA location number: _____

Date worker started employment: ☐☐ / ☐☐ / ☐☐☐☐

Address of worker's usual workplace (if different from above)

_____

Suburb / town: _____ Postcode: _____

### 5B - Employer contact person for this claim

(e.g. Manager or Return to Work Coordinator)

Name: _____

Phone: _____

Position title: _____

Email: _____

### 5C - Employment type

Is the worker any of the following? (if not leave blank)

☐ an apprentice ☐ a trainee ☐ a working director

If the worker is not an employee what is the relationship?
(e.g, non-working director, sole contractor, partner):

_____

### 5D - Worker's occupation and main tasks

Occupation: _____

Main tasks: _____

_____

_____

## Section 6 - Income support

Please complete section 6 if claiming for loss of wages.

### 6A - Worker's hours

Is the worker:

☐ permanent or ☐ casual

Normal hours per week? _____ hours

Regular hours each day of the week:

| Mon | Tue | Wed | Thu | Fri | Sat | Sun | |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | OR |

☐ tick if not regular hours (e.g. shi work)

Is the worker:

☐ full time or ☐ part time

If the worker works part time, what would their hours be

if they worked full time? _____ per week (if known)

### 6B - Worker's income details

What was the worker's gross weekly wage at

the time of the injury? $ _____

Does the worker normally work overtime?

☐ Yes ☐ No

If yes, what is the average amount earned per week? $ _____

What are the average hours of overtime per week? _____

Does the worker receive non-cash benefits? Yes ☐ No

If 'Yes' what is the benefit? (e.g. car, phone, computer)

_____

N e h f age f a a be e ed de de e e
A e age Wee Ea g

### 6C - Other employment details

Does the worker have any other current employment?

☐ Yes ☐ No

## Section 7 - EFT details

Payments and reimbursements are paid by EFT.

### 7A - Worker's Electronic Funds Transfer (EFT) details

Bank name: _____

BSB number: ☐☐☐ / ☐☐☐

Account number: _____

Account name: _____

### 7B - Employer's EFT details

Bank name: _____

BSB number: ☐☐☐ / ☐☐☐

Account number: _____

Account name: _____

## Section 8 - Notification of injury

Notification details

When was the employer notified of the injury?

Date: ☐☐ / ☐☐ / ☐☐☐☐

Name of person notified: _____

Position/title of person notified: _____

Person notifying: ☐ Worker ☐ Other, please specify:

_____

Date claim form given to/completed with employer:

☐☐ / ☐☐ / ☐☐☐☐

## Section 9 - Other information

Provide any other information relevant to the assessment of the claim:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Important information—read before completing

## Next steps

When the claims agent receives this completed claim form they:

> will contact the worker and employer

> may request additional information such as information to assist in determining the rate of weekly payments

> will assess and determine the claim for income support and/or medical services

> will arrange services to help the worker to recover and return to work. This may include visiting the worker and the employer if the worker is likely to be away from work for more than two weeks.

Workers of self-insured organisations should discuss the next steps with their employer.

Keep a copy of this completed form for your records.