

IMPORTANT INFORMATION
please read this first

employer's report of injury

australian capital territory

Instructions

- Please print clearly.
- Unless otherwise directed, all quotes on the form must be answered.
- Provide any relevant additional supporting evidence and attach it to your claim at the time of lodgement.
- Keep a photocopy of the completed form for your records.

Section 1 employer's details

Full Name of Employer

ABN

Telephone Number ()

Fax Number ()

Policy Number

Postal Address
 Postcode

Location Address (Specify street address)
 Postcode

Business Activity or Profession

Workplace Size

Location where employed (e.g. depot, cost centre, branch)

Employment classification of worker (e.g. profession, trade)

Name of Employer Representative to contact about this claim

Representative Telephone Number ()

Section 2 claimant's details

Family Name

Given Name

Residential Address
 Postcode

Telephone Number ()

Sex Male Female

Date of Birth / /

Date Employed / /

Worker's occupation

Apprentice Trainee

Date employed / /

What are the worker's main duties?

Employment Status Full time Part time Permanent Casual Contractor

Casual: Hours worked per week

Where does the worker usually perform their duties?

Where is the worker's base for the purpose of this employment?

In what state or territory was the worker initially hired or taken into employment?

Section 3 Claimant's Award Information

Please indicate
Federal Award
State Award
Registered Enterprise Agreement
Registered Industrial Agreement
No Award or Agreement

Award or Agreement Title

Worker's Classification Number

Actual earnings of the injured worker during the past 12 months?
\$

Actual hours worked during the past 12 months, including overtime? *

If the employment period is less than 12 months, what is the period of employment?

Actual hours worked during the actual period of employment, including overtime? *

Actual earnings of the injured worker during the actual period of employment?
\$

Hours worked overtime per week *

Overtime rate(s) per Hour

* Only include overtime details if they are worked in a regular and established pattern, were substantially uniform as to the number of hours and would have continued but for the injury.

Section 4 injury details

Date of injury / / Time

Date reported / / Time reported

Date Insurer notified / /

To whom was the report given?

If the Insurer was not notified within 48 hours of first becoming aware of the injury please provide reasons.

Three empty text input boxes for providing reasons.

Where did the injury occur?

- At work: normal workplace
- At work: not normal workplace
- At work: road accident
- At work: during break
- Away from work: during break
- Travelling to or from place of employment

Place and address where the injury occurred

Two empty text input boxes for address.

What injury/disease has the employee sustained?

One empty text input box for injury/disease.

Which parts of the body were injured

Two empty text input boxes for body parts.

Describe in detail how the injury/disease occurred

Five empty text input boxes for detailed description.

Name of Witness 1

One empty text input box for witness name.

Address of Witness 1

Two empty text input boxes for address and postcode.

Telephone Number

One empty text input box for telephone number.

Name of Witness 2

One empty text input box for witness name.

Address of Witness 2

Two empty text input boxes for address and postcode.

Telephone Number

One empty text input box for telephone number.

Details of any previous, related injuries claimant may have suffered

Four empty text input boxes for previous injuries.

Section 5 lost time particulars

Date worker ceased work

Three empty text input boxes for date (/ /).

Time

One empty text input box for time (am/pm).

Has worker resumed work?

No Yes Date resumed work

Time

Exact time lost

One empty text input box for exact time lost.

Award hours worked per week

One empty text input box for award hours.

Normal working hours (e.g. 7am – 4pm Monday to Friday)

One empty text input box for normal working hours.

Section 6 present capacity

Has the worker resumed work?

Full time Part time on Pre-Injury duties Modified duties

Do you have suitable duties available to the injured employee, given their stated restrictions?

One empty text input box for suitable duties.

Provide details of any part time/modified duties

Three empty text input boxes for part time/modified duties.

Section 7 details of any other circumstances which may assist us to assess claim (ie. do you query the validity of the claim?)

Eight empty text input boxes for other circumstances.

Section 8 declaration by employer

I, (print name and position)

Two empty text input boxes for name and position.

Declare that the details given above are true and correct in every particular.

Signature

One empty text input box for signature.

Date

