

recurrence of disability

western australia

To be completed where a worker has lost further time following a return to work or where there has been a renewal of treatment of the original disability. Attach medical certificates and reports if available.

Section 1 worker

Surname	<input type="text"/>	Other Names	<input type="text"/>
Address	<input type="text"/>	State	<input type="text"/>
	<input type="text"/>	Postcode	<input type="text"/>
Current Employer	<input type="text"/>	Claim Number (if known)	<input type="text"/>
Employer at time of original disability	<input type="text"/>		
Nature of disability	<input type="text"/>		
Date of original disability / injury	Date of further period of incapacity or treatment	Date of return to work	
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	

Section 2 recurrence details

1. (a) Describe in detail where you were and what you were doing when the latest onset of symptoms or incapacity occurred

(b) If a further incident occurred, please provide details of this further incident

2. Were there any witnesses to the onset of further symptoms? No Yes If Yes, provide names and addresses, and attach statements (Form S can be used)

3. Was the onset of symptoms reported? No Yes If Yes, when? / /

And to whom?

4. (a) State what symptoms, if any, you have been experiencing leading up to the latest onset of symptoms

(b) What medical treatment have you been receiving prior to the latest onset of symptoms?
State the names of treating Doctors and of treatment

(c) Give full details of every Doctor or medical professional upon whom you have attended since the initial date of incident

Section 2 recurrence details (continued)

5. Give full details of your employment between the date of the original disability and current disability.
Supply names of all Employers, dates worked and occupation

Section 3 declaration

I solemnly and sincerely declare that each and every answer above and the particulars contained herein or annexed hereto relating to myself and the occurrence are true both in substance and in fact to the best of my knowledge and belief.

I take notice that under the provisions of Section 59 (1) of the Workers' Compensation and Rehabilitation Act, 1981, I am required to notify my Employer within 7 days should I commence work with another Employer after making a claim, or while receiving weekly payments of workers' compensation.

I hereby authorise any Doctor to divulge to my Employer, or their Insurer and its professional advisors, information in relation to my claim for workers' compensation which he or she may have acquired with regard to myself for this claim and for any earlier injuries, disabilities and conditions that may have any relevance to this claim.

Dated the day of 20

Signature of Worker

Signature of Witness

Note: Failure to sign medical authority may delay the processing of your further claim for incapacity or treatment.