University of Western Sydney

Locked Bag 1797
Penrith South DC NSW 1797 Australia
Occupational Health & Safety Risk Management Unit
Tel 02 9852 5179/5180 Fax 02 9852 5181

IMPORTANT INFORMATION – BEFORE YOU START

To avoid delay accessing workers compensation benefits you MUST notify your supervisor at the earliest possible time if you have been injured at work.

The following four forms (6 pages in all) are to be completed in EVERY case when claiming workers compensation.

- Initial Notification of Injury (1 Page)
- Workers Compensation Claim Form (2 Pages)
- UWS Information Consent Form (1 Page)
- UWS Accident/Injury/Incident/Hazard Notification Form (2 Pages)

Claimants MUST complete the forms fully and provide as much information as possible regarding the injury.

THERE IS NO NEED TO COMPLETE THE EMPLOYERS SECTION of the Workers Compensation Claim Form as this will be completed by the OHS&R Unit.

After completing the forms the following actions MUST BE taken:

1. FAX the forms directly to the UWS Injury Coordinator (9852 5181), AND THEN
2. MAIL the originals to the OHS&R Unit, Building BO, Werrington South

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Failure to complete ALL forms may delay access to benefits.

Employers Mutual Indemnity (Workers Compensation) Limited
ABN 52 003 201 885

CML Building,
Level 6, 14 Martin Place
Sydney 2000

Address all mail to:
GPO Box 4143
Sydney 2001
DX 10175 Sydney Stock Exchange

Ph: (02) 9229 7900
Fax: (02) 9233 4885 (Underwriting)
(02) 9233 8980 (Claims)

Initial Notification of Injury – Fax Form

Notification No.: ....

This form is to be used when an employee suffers an injury or illness where workers compensation is or may be payable and a claim form has not been completed. The boxed areas must be completed to be considered an "initial notification". Please supply us with as much information as possible to allow us to make payments and develop an Injury Management Plan (if required).

Employer Name*: [ ]
Business Address:** [ ]
Policy No: ....
Post code: [ ]

Workplace Address***: .... Post code: ....
Contact Name .... Phone: ....
Contact Email: .... Fax: ....
Nominated Rehab Provider: .... Significant Injury: ☐ Yes ☐ No

* include trading name or cost centre where applicable ** if policy no. unknown *** if different from business address

Worker's Name: [ ]
Address: [ ]
Sex: ☐ F ☐ M
Post code: [ ]
Phone No: .... ☐ Permanent ☐ Casual
DOB: [ ]
Interpreter ☐ No ☐ Yes, Language .... ☐ F/T ☐ P/T
Occupation: .... Hrs/week: ....
Main Tasks: .... Award Rate: $ ....

How injury occurred: [ ]
Details of injury: [ ]
Injury Date: [/ /]
Injury Time: ....
Accident Location: ....

Treating Doctor or Hospital (if admitted) [ ]
Phone: ....
Dr / Hospital Address *: .... Fax*: ....
* if phone no. unknown

Medial Certificate from: .... Medical Cert to: .... Incapacity: ☐ **Total** ☐ **partial**
Second Injury: ☐ Yes ☐ No Date Ceased Work: .... Expected RTW Date: ....
Claim Lodged: ☐ Yes ☐ No Date RTW Partial: .... Date RTW normal: ....

Comments: ....

....

....

Notifier's Name: [ ]
Relationship to worker: ☐ Worker ☐ Employer ☐ Other-specify
Contact No: [ ]

Office user only

Criteria Met: ☐ 1 - Minimum identifying information ☐ 2 - Medical information
☐ 3 - Injury work related ☐ 4 – Worker is a worker.

Claim Forms Posted: ☐ Yes ☐ No

Workers Compensation Claim Form

Employers Name: ______________________ **Claim Number:** ____________

Complete all questions fully and accurately, to ensure accurate decisions can be made about your claim

A separate "Injury on the Journey" form must be completed if you were injured on a journey.

1. Worker's Particulars

Family Name ____ Male ☐ Female ☐

Given (or first) Name(s) ____

Date of Birth (DD/ MM/ YYYY) / / Telephone contact number ____

Residential Address ____

Post code: ____

Interpreter required? Yes ☐ No ☐

Language ____ What is country of birth ____

2. Injury Details

How did the injury occur, and what were you doing when the injury happened? (e.g. slipped when climbing a ladder)

____

What part/s of your body is/are injured?

____

Was this part/s of your body normal before the injury? Give details.

____

What is the address where the injury happened? (if different to work address)

____

Post code: ____

Date of Injury (DD/ MM/ YYYY) / / Time of injury HH:MM HH: MM: AM ☐ PM ☐

Did anyone see your accident? No ☐ Yes ☐

If yes, names: ____

Name of person at your workplace you reported the injury to?

Name and position ____ Date reported (DD/ MM/ YYYY) / /

What is the name of your Nominated Treating Doctor?

Name ____ Telephone Number ____

Other similar Injuries

Have you previously suffered any similar injuries or conditions? Please give details (for example, when this happened

____

3. Injured workers declaration

I certify that the information I have provided is correct. I consent to the insurer and its appointed service providers collecting personal information about me and using it for purpose of assessing and managing my worker's compensation claim, including determining liability and whether my claim is true. I consent to the insurer disclosing my personal information to medical practitioners, rehabilitation providers, investigators, legal practitioners and other experts or consultants for the purpose of assessing and managing my claim. I also consent to the insurer disclosing my personal details to the WorkCover Authority, which is authorized to use this information to fulfil its functions under the NSW workers compensation legislation.

I understand that is any information I have given is untrue, that my claim may be denied and that I may be prosecuted.

Note: *a photocopy of this authority shall be as valid as original.*

Signature of injured worker ____ Date / /

YOU MUST ALSO COMPLETE THE INFORMATION ON THE BACK OF THIS FORM BEFORE THE FORM IS SENT TO THE INSURER

Employers' Mutual Indemnity (Workers Compensation) Limited ABN 52 003 201 885. Employers' Mutual Limited ABN 67 000 006 486. CML Building, Level 6, 14 Martin Place, Sydney 2000. Ph: (02) 9229 7900 Fax: (02) 9290 2405.
Address all mail to: GPO Box 4143 Sydney 2001

Please complete as many of the following details that you know. This will help the insurance company process your claim as quickly as possible **If you don't know all the answers ask your employer or supervisor to complete this part of the form**

4. Work details

a) The job where you were injured

What is your:

Occupation | Workplace industry

Are you: ☐ Trainee ☐ Contractor/Sub-contractor ☐ Apprentice ☐ N/A

Address Were you work most of the time

Post code:

What is your weekly

Gross Normal Pay | Gross Basic Award Rate

How many total hours do you work per weeks?

HH: MM: HH:MM

What are your normal working hours? e.g. 7am to 4pm :: Mon-Fri

Do you have an Enterprise Agreement or Workplace Agreement? ☐ No ☐ Yes

An Award? ☐ No ☐ Yes Name:

How many people work at your workplace?

How many work: ☐ Full-time ☐ Part-time and ☐ Permanent ☐ Casual

b) Other jobs

Do you have a second job with other employer?

No ☐ Yes ☐

Name of second employer

Contact Name | Telephone Number

What is your gross pay weekly in this job?

$

How many total hours do you work per week in this job?

HH: MM: HH:MM

5. Your Employers Particulars for the job where you were injured

Business Address (if different to above)

Post code:

ABN or Policy Number

Cost Centre

Workplace Contact for Injury

Name | Phone Number

6. What to do next

1. Make sure you have completed both sides of the form
2. Sign the declaration on the first page
3. Attach any WorkCover medical certificates to this claim form
4. Attach a copy of your payslips
5. Give this form to your employer or insurer

Date given to employer / / **OR** Date given to insurer / /

Received by Employer

Name and position | Date received / /

Additional Information (from either the injured worker or the employer):

Please attach any additional information directly to this form

UWS INFORMATION CONSENT FORM

I ______________________________ authorise the UWS Injury Management
(name)

Co-ordinator, of University of Western Sydney to:

OBTAIN/RELEASE information either verbal or written, in relation to my rehabilitation from (insert names):

a) UWS Manager/Supervisor/ HR Representative ______________________________
b) Treating Medical Practitioner ______________________________
c) Specialist ______________________________
d) Physiotherapist/Chiropractor ______________________________
e) Hospital ______________________________
f) Rehabilitation Provider ______________________________
g) Union (if applicable) ______________________________
h) Other ______________________________

AND TO

OBTAIN/RELEASE information concerning relevant aspects of the workers compensation claim, and discuss that information with persons nominated below: (insert names)

a) UWS Manager/Supervisor/ HR Representative ______________________________
b) Treating Medical Practitioner ______________________________
c) Specialist ______________________________
d) Physiotherapist/Chiropractor ______________________________
e) Hospital ______________________________
f) Rehabilitation Provider ______________________________
g) Union (if applicable) ______________________________
h) Other ______________________________

The information provided will be of a factual nature concerning the rehabilitation (return-to-work) programme and claims management and a copy of any relevant written report may be provided. All aspects of information release and discussions will be subject to strict confidentiality guidelines.

I understand that I may change or cancel this authority at any time, however, claim/rehabilitation status and/or continuing benefits could be affected.

______________________________ ______________________________

Signature Date

In certain circumstances, some organisations are legally entitled to receive rehabilitation information about an injured worker – for example, insurers, legal adviser, the WorkCover Authority, and a NSW Court of Law.

Appendix III		
Date Rec.		
WorkCover	Yes	No
Date:		

UNIVERSITY OF WESTERN SYDNEY

Accident/Injury/Incident/Hazard Notification

REPORT

Who was Injured? (If there was **NO** injury, write down who is completing the report)

Name: ....

Address: ....

....

Tel: (H) .... (W) ....

Staff	Student	Visitor Purpose of visit:	Contractor Company Name:

....

Accident date: ...../...../..... Time: .....:..... am/pm

Accident Reported to: ....

Date of Birth: ...../...../.....

Country of Birth: ....
(WorkCover Requirement)

College/Division: ....

School/Department: ....

Direct Supervisor: ....

Campus: ....

Location of accident/incident/hazard: ....

(eg. Bldg/Room/No./Street Name)

INJURY

What type of injury?

Part of body injured (be specific): ....

Nature of Injury: ....

Action Taken **First Aid** ☐ **Medical treatment** ☐ **Other** ☐ Details: ....

Was Time Lost? **NO** ☐ **Yes** ☐
If YES – specify hours ....

INVESTIGATION

How did it happen?

Describe clearly how the Accident/Incident/Hazard occurred. Be specific attach statement if required.

....

....

....

....

Name and Address of Witnesses

....

Type of Accident

☐ Slips/trips/falls
☐ Extreme temperature
☐ Cuts/Sharps
☐ Repetitive muscular/skeletal injury
☐ Striking an object
☐ Abrasions/Bruise
☐ Manual Handling (pushing, pulling)
☐ Other ....

Agency of Injury

☐ Plant/machinery
☐ Environment
☐ Vehicle
☐ Static equipment (e.g. computer w/station)
☐ Hand Tools
☐ Live Animals
☐ Hazardous substances
☐ Other ....

Signature of person completing form: .... Date: ....../...../.....

SUPERVISOR TO INVESTIGATE AND COMPLETE BACK OF THIS PAGE

General Staff and/or Academic Supervisors complete this section following Investigation of the accident/injury/incident/hazard

PREVENTION

What action can be taken to prevent accident recurrence?

- ☐ Equipment Machinery Modification or Maintenance
- ☐ Improve personal protection
- ☐ Improve design/construction
- ☐ Enhance to training and instruction
- ☐ Change to work procedures
- ☐ Use of safer materials
- ☐ Improve housekeeping
- ☐ Re-education of staff
- ☐ Improve work organisation
- ☐ Other – Preventative action (please specify)

....

....

Specify measures already taken (attach extra sheet if needed)

....

....

....

....

....

Any further comments

....

....

....

Supervisors details

Name: .... Signature .... Date: ____/____/____

RETURN THIS FORM TO YOUR CAMPUS OCCUPATIONAL HEALTH, SAFETY & RISK UNIT

This form must be returned IMMEDIATELY after completion or within 48 hours of the Accident/Injury/Incident/Hazard

OHS Office use ONLY

Final lost time [hrs]

Investigation completed (Yes) (No) IF NO – Further action required

....

....

....

....

OHS Staff Signature: ....