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

University of Western Sydney

IMPORTANT INFORMATION – BEFORE YOU START

Have you obtained a WorkCover Medical Certificate from your treating Doctor?

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 (7 pages in all) are to be completed in EVERY case when claiming workers compensation.

- Initial Notification of Injury (1 Page)
- Workers Compensation Claim Form (3 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.

Do not complete Section 5 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

Employers Mutual NSW Limited

ABN 52 003 201 885

SYDNEY

Level 3, 345 George Street, Sydney NSW 2000
GPO Box 4143 Sydney NSW 2001
DX 10175 Sydney Stock Exchange
Tel 02 8251 9000
Toll Free 1800 469 931
Fax 02 8251 9495 (Claims)

NEWCASTLE

53 Cleary Street, Hamilton NSW 2303
PO Box 776 Hamilton 2303
DX 4332 Newcastle West
Tel 02 4969 0200
Fax 02 4965 4083

Since 1910
Employers
Mutual

Information in the event of a workplace injury/illness

At Employers Mutual, we aim to assist employers and injured workers achieve a timely and safe return to work by providing *efficient* friendly service and advice, *mutual* benefits to members and *individual* customer service.

The following information can assist in minimising your Worker's Compensation costs:

- Ensure the worker receives necessary first aid and if required, referral to a medical practitioner for treatment ASAP.
- Ensure the details of the injury are entered in the Register of injuries as required by the Workplace Injury Management and Worker's Compensation Act 1998.
- Investigate the circumstances of the accident; take appropriate action to eliminate any hazards or further accidents.
- Notify WorkCover NSW of *reportable accidents* and other matters within 7 days, as required by the Occupational Health and Safety Act 2000. Reporting forms should be obtained from WorkCover NSW.
- Significant Injuries (worker partially or totally incapacitated for more than 7 days) must be notified to Employers Mutual within 48 hours of the employer being advised of the injury by an Initial Notification of Injury form. Employers Mutual may request a claim form to be completed.
- Non-significant injuries (where time is lost or treatment is required) must be reported to Employers Mutual within 7 days by either an Initial Notification of Injury form or a claim form.
- If claim forms are completed they must be sent to Employers Mutual within 7 days of receipt.
- Ensure that WorkCover medical certificates are sent to Employers Mutual within 7 days of receipt.
- Witness to injury forms should be completed where appropriate and forwarded to Employers Mutual.
- Journey claims require completion of a supplementary claim form.
- Contact by your designated Return to Work Co-ordinator with the worker and/or nominated treating doctor should be made as soon as possible to discuss return to work options.
- Forward a copy if developed, of the return to work plan / details of suitable duties undertaken by the injured worker to Employers Mutual.

Injury Management is a process comprised of activities and procedures that seek to achieve a timely, safe and durable return to work for workers following workplace injuries/illness.

- In the event of a significant injury being reported, Employers Mutual will attempt to contact the employer's designated person/return to work co-ordinator, the injured worker and where practicable the nominated treated doctor within 3 working days, to establish an injury management plan.
- Services/treatment may be approved under an injury management plan prior to determination of liability.
- The employer must provide suitable duties to an injured worker wherever reasonably practicable.
- Injury management plans will be developed and forwarded to all parties.
- The employer must comply with the obligations imposed under an injury management plan or be liable to a premium surcharge.
- Failure by an injured worker to participate and/or assist in the arrangement of an injury management plan will result in a suspension of benefits.
- An injured worker must nominate a treating doctor willing to participate in the development of and arrangements made under an injury management plan.
- An injured worker must contact Employers Mutual prior to a change of nominated treating doctor.
- Weekly benefits will commence within 7 days of receipt by Employers Mutual of Initial Notification or Claim unless insurer has a reasonable excuse as defined by WorkCover. A decision on liability will be made within 21 days of a claim lodged, unless parties are notified of an extension.
- Benefits at the basic award rate will be paid upon evidence of incapacity for a period of up to 26 weeks. Continuing incapacity will be paid at the statutory rate.

NOTIFY US IMMEDIATELY OF ALL NEW SIGNIFICANT INJURIES IN TWO EASY STEPS:-

- Complete the Initial Notification of Injury – Fax Form overleaf.
- Fax it to us straight away on **02 8251 9495 or** phone us on 02 8251 9000.

(On-line reporting also available at our website – www.employersmutual.com.au)

Workers Compensation Claim Form

Since 1910
Employers Mutual

Employers Name

Claim Number

Complete all questions fully and accurately, to ensure 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

First Name(s) | DOB D D / M M / Y Y

Residential Address

Post Code | Phone

Interpreter Required No | Yes | Language | What is your country of birth?

2 Injury Details

How did the injury occur, and what were you doing when the injury happened? (eg. 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 D D / M M / Y Y Time of injury HH:MM HH MM

Did anyone see your accident? No | Yes

If yes, names:

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

Name

Postition

Date Employer Notified of Injury D D / M M / Y Y

Date reported D D / M M / Y Y

What is the name of your Nominated Treating Doctor?

Name

Telephone

Other similar injuries

Have you previously suffered any similar injuries or conditions? Please give details

3 Injured worker's declaration

I certified 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 the 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 purposes of assessing and managing my claim. I also consent to the insurer disclosing my personal details to the WorkCover Authority which is authorised to use this information to fulfil its functions under the NSW workers compensation legislation. I understand that if 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 valid as original.

Signature of injured worker

Dated D D / M M / Y Y

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

Please complete as many of the following details that you know. This will help Employers Mutual 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

Occupation ______ Workplace Industry ______

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

Address where 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 week? HH:MM HH MM

What are your normal working hours? eg. 7am – 4pm Mon-Fri ______

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

Name of agreement or award ______

How many people work at your workplace? ______ Full-time ☐ Part-time ☐ and Permanent ☐ Casual ☐

b) Other jobs

Do you have a second job with another employer? No ☐ Yes ☐

Name of second employer ______

Contact Name ______ Phone ______

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 ______

6 What to do next

1 Make sure you have completed both sides of this 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 D D / M M / Y Y or Date given to insurer D D / M M / Y Y

Received by Employer

Name and position ______ Date received D D / M M / Y Y

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

PLEASE ATTACH ANY ADDITIONAL INFORMATION 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: ....

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

Address: ....

....

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

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

College/Division: ....

Staff	Student	Visitor Purpose of visit:	Contractor Company Name:

....

School/Department: ....

Direct Supervisor: ....

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

Campus: ....

Accident Reported to: ....

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: ....