Workers Compensation Reimbursement Invoice

Claim No.

Policy No.

Please PRINT IN BLOCK LETTERS and answer all Questions ☑ where applicable (provide full and complete answers). If a particular question does not apply, please write "N/A" in the space provided. If the space provided below is insufficient to advise all the details, please attach a separate sheet.

EMPLOYER'S DETAILS

Employer's Name …… Employer's Reference No.……..

Address…….

…...…… Postcode ……..

Worker's Name ……

GENERAL QUESTIONS

(1) Is the worker a shift worker? No ☐ Yes ☐

(2) What are the worker's regular hours? ……..……...……...……

(3) What are the worker's normal days off duty? ....……...……...……

(4) Did the worker have any rostered or accrued days off during the compensation period claimed? No ☐ Yes ☐

If "yes", which days?.....

(5) Has the worker resumed duties? No ☐ Yes ☐

If "yes", please indicate whether the worker has resumed:

(a) Normal Duties ☐ When ……/……./……. Hrs/week ……

(b) Lighter Duties ☐ When ……/……./……. Hrs/week ……...……...

Period (inclusive dates)		**Weeks**	**Days**	**Hours**	**Weekly Rate**	**Amount**
From	**To**					
					$	**$**
					$	**$**
					$	**$**
					$	**$**
					$	**$**
					$	**$**
					$	**$**
					$	**$**
					$	**$**
					$	**$**
					$	**$**
					$	**$**
					Total	**$**

IMPORTANT

(1) If compensation relates to time lost visiting doctor and is less than one day, show "TLVD" against period and indicates hours lost each visit.
(2) Ensure that medical certificates supporting periods of absence are submitted.
(3) Specific actual dates. Do not use "week ending" or retrospective.

EMPLOYER'S SIGNATURE

Name……..…….…… Signature……..…… … Date……/……./…….

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