



A SUNCORP COMPANY

Employer's Report of Injury

DO YOU SUPPORT THIS CLAIM YES / NO

(Before completing this form, please read the notes on the back. Print in block letters and circle where appropriate)
Level 9 66 St Georges Terrace Perth WA 6000. GPO Box B50 Perth WA 6001. Telephone (08) 9320 3600 Facsimile (08) 9322 6583

COMPLETE ALL QUESTIONS, PARTIALLY COMPLETED FORMS WILL BE RETURNED

Employer details

Full name as per policy:

Trading Name:

Policy No: WA

Telephone Number

Fax No

Email

Postal Address

Postcode

Name of Site and/or Location address where injured person actually works

Cost Centre

Business Activity/Profession: (use 2 words or more)

Injured person's details

Surname

Given Names

Address:

Postcode

Telephone number

Date employed

Date of birth

Place of birth

Height

Weight

Sex: Male

Female

Employed: Full Time

Part Time

Casual

Marital Status: Married/De facto

Single

Occupation

Is injured person a contractor or subcontractor? Yes No

If "YES", attach a copy of any written agreement or contract, together with twelve months of their invoices if applicable.

Is she/he a director or family member? Yes No

If "Yes", please tick which

Director

Family member

If a family member, does she/he live with the Insured? Yes No

Injury details

Date of injury

Time of injury

Date Employee Claim form received

To whom was accident reported

Position

Date first medical received

Name and address of witness

Postcode

Location address where injury occurred

Postcode

When did the accident occur?

At work

During work break

Away from work during a break

Motor vehicle accident whilst working

Travelling to or from place of employment

Injury details continued

How did the injury occur?

What was the injured person doing at the time?

Was the injured person performing his/her normal duties?

Yes No

If "No", why were they doing this task?

Is protective equipment/clothing required for the task?

Yes No

If "Yes", what type?

Was the above clothing/equipment being worn at the time of the injury? Yes No

If "No", why?

Is this a recurrence/aggravation

Yes No

If "Yes", provide details of previous injury including the Insurer's claim number if known

Describe the injured person's injury or condition (eg laceration, dermatitis)

Which part of the body is injured (eg left upper arm, right ankle)

Was First Aid treatment given?

Yes No

If "Yes", by whom?

What treatment was provided and for what period?

Name of Doctor first attended

Hospital admitted to and date

Give details of any other circumstances that would assist GIO to assess the claim.

(Include in here queries as to the validity of the claim eg misconduct, skylarking or pre-existing disabilities contributing to the injury or accident.) In my opinion:

Time loss details

(show N/A if there is no lost time)

Date ceased work

Time

Date work resumed

Time

If work has not been resumed what is anticipated date of return

Weekly compensation

(complete only if there is or will be lost time (eg surgery anticipated))

How many days per week

and hours per day

does the injured person work?

What is the start time

and finish time?

Is this the same everyday? Yes No

If "No", please provide details

Please show whether the injured person is employed under

1. Industrial Award or 2. Other

If option 1:

What is the full name of the Award?

is it: State or Federal

Weekly compensation continued

Please also complete the 13 weeks wage information below to enable us to advise you of the correct rate of pay or provide a print-out of payment records.

Week No	Week Ending	No of Hours Worked	Award Rate \$	Overtime \$	Allowances \$	Other \$	Total \$	
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
AVERAGE (÷13)				\$		GRAND TOTAL		\$

If option 2: Please provide the total amount paid to the injured person during the 12 months immediately prior to the accident or for such lesser period as applies and ensure that the "Date Employed" is completed in the "Injured Person's details" section on page 1.

Total "wages" paid \$ for weeks (please provide print out of pay records)

Rehabilitation

The Injury Management Process in Western Australia requires consultation between the employer, the medical practitioner and the injured person before the injured worker is referred to an approved rehabilitation provider for an assessment. An employer is able to authorise their insurer to act on their behalf in the consultation process with the medical doctor to support the employee in their appointment of an approved vocational rehabilitation provider for a vocational assessment.

Do you have a delegated rehabilitation coordinator? Yes No If Yes, name telephone number

Has injury management commenced? Yes No If Yes what actions have been taken

Signature Position Date / /

Declaration

I, (print name, position)

declare that the details above are true and correct in every particular. Signature Date / /

EMPLOYERS PLEASE NOTE

- This notice of claim must be forwarded within 3 days of lodgement of claim by the injured person. This also applies to any documentation received in respect of the claim.
 - Please attach Employee Claim Form 2B and 1st Medical Certificate.
- If the injured person has not resumed work at the time of lodgement of this claim, it is important that you notify the insurer immediately the injured person returns to work.
- No compensation or any other payments eg medical are to be made without prior written approval of the insurer.

