vero
workers compensation

WORKERS COMPENSATION REIMBURSEMENT

WORKERS NAME	
EMPLOYER'S NAME	
EMPLOYER'S ADDRESS	
OUR CLAIM NO	

1. Is the worker a Casual/Part-time Worker? ______________________

2. Is worker paid under an:

   Workplace Agreement ☐ **Enterprise Bargaining Agreement** ☐

   Award ☐ **Other;** ☐
   Please sepcify which Award: Please specify:

   ______________________ ______________________

3 What are the Worker's regular hours? ______________________

4. What are the Worker's normal days off duty? ______________________

5. Did the Worker have any days off duty during the compensation period claimed? **Yes / No**

6. If yes, which days? ______________________

7. Has the Worker resumed duties? **Yes / No** When? **/ / 20**

Period of compensation claimed (inclusive dates)						
From	**To**	**Weeks**	**Days**	**Hours**	**Weekly Rate $**	**Amount $**
					TOTAL:	

IMPORTANT

WHEN COMPLETING THE ABOVE SECTION PLEASE ENSURE THE FOLLOWING:
- THAT YOU HAVE MEDICAL CERTIFICATES SUPPORTING THE PERIOD OF ABSENCE
- THE WORKER IS PAID STRICTLY IN ACCORDANCE TO THE RATES OF PAY ADVISED BY OUR OFFICE
- USE SPECIFIC ACTUAL DATES ABSENT FROM WORK. PLEASE DO NOT USE 'WEEK ENDING' OR 'PAY PERIODS'

DATE: / / 20 **EMPLOYER'S SIGNATURE:** ______________________

OFFICE USE ONLY:	
CMN:	
Payee	Entered by
Date	Amount
Payment No	Authorised by