SAVE AS PRINT

NSW GOVERNMENT WorkCover

Claimant Name | Date of Injury / / | Claim no.

WORKERS COMPENSATION ACT 1987

OTHER WORK RELATED INJURIES CLAIM FORM

This supplementary information is to be provided by:

a) A worker in respect of:
- an injury received while on the daily or other periodic journey between the worker's place of abode and place of employment, or between the place of abode and any trade, technical or other training school, where there is a real and substantial connection between the employment and the accident
- an injury received while on a journey between the worker's place of abode and other places referred to in section 3(c) – (g) of the *Workers Compensation Act 1987*, where there is a real and substantial connection between the employment and the accident
- an injury received while on a journey between the worker's place of employment and other places referred to in section 3(c) – (g) of the *Workers Compensation Act 1987*
- an injury received while away from work during an ordinary recess and for an injury involving a motor vehicle accident in the course of employment.

b) Those parties exempt from the 2012 legislation changes (police officers, paramedics, firefighters, coalminers, emergency service workers and rescue association workers) in respect of:
- an injury received while on the daily or other periodic journey between the worker's place of abode and place of employment or to any trade, technical or other training school, or otherwise in the course of their employment
- an injury received while on a journey between the worker's place of abode or place of employment and other places referred to in section 3(c) – (g) of the *Workers Compensation Act 1987*
- an injury received while away from work during an ordinary recess and for an injury involving a motor vehicle accident in the course of employment.

Please complete this form in BLOCK letters and use a black pen.
If further space is required, attach a separate page.

Please indicate in which State you want to lodge this claim:
New South Wales ☐ Queensland ☐ Victoria ☐

1 WORKER'S DETAILS

Family name

Given names

Date of birth / / **Sex** Male ☐ Female ☐

Address

Suburb **Postcode**

Phone Mobile

Employer's name

Address

Suburb **Postcode**

Phone Fax

Email

2 JOURNEY DETAILS

Date and time of accident
Date / / Time : AM/PM

What mode of transport were you using?
eg. motor vehicle, public transport, walking, other

Where exactly did the accident occur? eg. street

Suburb **Postcode**

Where were you travelling to? – eg. work, home, technical school

Where were you travelling from? – eg. work, home, technical school

Did the accident involve a motor vehicle whilst you were working? Yes ☐ No ☐

What time did you leave work, home, technical school? : AM/PM

Were you on a recess or authorised break? Yes ☐ No ☐

What was the purpose of your journey?

What is your usual route for this journey?

Did you divert from your usual route? Yes ☐ No ☐
If Yes, provide details

Was there any interruption to the journey for any reason?
Yes ☐ No ☐ If Yes, provide details

Had you consumed any alcohol or drugs in the 12 hours immediately prior to the accident? Yes ☐ No ☐
If Yes, how much?

Claim no.

How did the accident occur? Please provide a detailed description.

Contact details of witnesses

Full name	Address	Phone number

In your opinion, who was responsible for the accident? Why?

3 TRAFFIC ACCIDENT DETAILS

All traffic accidents in which someone is injured, must be reported to the police as soon as possible but no later than 28 days after the accident. If you have not reported your accident, you should do so immediately.

A. IF YOU WERE INJURED IN A TRAFFIC ACCIDENT

Police station to which the accident was reported

Date / /

Police officer's name

Did police attend the accident? Yes No

Police reference number

Police action taken or proposed

If you were a driver/passenger, were you wearing a seatbelt?

Yes No

If you were a rider/passenger, were you wearing a helmet?

Yes No

Using the symbols below, draw a diagram of the accident scene showing the position of all vehicles and indicate by arrows the directions of travel.

Your vehicle

Other vehicle

Pedestrian , cyclist etc

Intersection

Claim no.

B. ABOUT THE VEHICLE IN WHICH YOU WERE INJURED

Registration number | **State of reg.**

Driver's name

Driver's licence number

Residential address: Street

Suburb | **Postcode**

Phone: Work

Phone: Mobile

Phone: Home

Vehicle owner's name (if different from driver)

Vehicle owner's contact details (if different from driver)

C. OTHER VEHICLES INVOLVED

(if more than two vehicles, attach a separate list)

Registration number | **State of reg.**

Driver's name

Driver's licence number

Residential address: Street

Suburb | **Postcode**

Phone: Work

Phone: Mobile

Phone: Home

Vehicle owner's name (if different from driver)

Vehicle owner's contact details (if different from driver)

4 NON WORKERS COMPENSATION CLAIMS

Have you made a personal injury claim other than a workers compensation claim regarding this accident?

Eg. a CTP claim or a public liability claim Yes ☐ No ☐

If Yes, provide details including the type of claim

Name of insurer

Claim/reference number

5 DECLARATION

I have read the information provided in this form. I declare that the information that I have supplied in this form, and any attachments to this form, is true and correct to the best of my knowledge. I understand that the making of a false or misleading statement in support of the claim is punishable by law and that I may be prosecuted.

I authorise and consent to any person who provides a medical or hospital service to me in connection with an injury/condition to which this claim relates to provide upon request by the workers' compensation authority, my employer or insurer/claims agent, any information regarding the service relevant to the claim. I understand that my authority has effect and cannot be revoked for the duration of this claim.

I authorise and consent to the collection, disclosure and release of any personal and health information in connection with an injury/condition to which this claim relates. I understand that if this claim results in me receiving weekly compensation payments, I am required to notify whomever is paying my benefits if I commence employment with some other person or in my own business, or of any change in my employment that affects my earnings, and that failure to do so is an offence. I consent to the WorkCover Authority of NSW using the information collected in connection with my claim for the purposes of research about workers compensation, workplace injury management and occupational health and safety.

Signature of injured worker

Date / /

Catalogue No. **WC05518** WorkCover Publications Hotline **1300 799 003**
WorkCover NSW 92-100 Donnison Street Gosford NSW 2250
Locked Bag 2906 Lisarow NSW 2252 WorkCover Assistance Service **13 10 50**
Website www.workcover.nsw.gov.au **0912**