Claim Form

Employer's Report of Injury

Employer's Report of Injury

Employer Cost Centre: | GIO Reference Number:

Injury Register ☐ Report Only to Insurer ☐ Early Injury Management Request ☐ Claim ☐

(Select one or more of the above choices, as appropriate.)

TO BE COMPLETED BY EMPLOYER'S AUTHORISED PERSON.
Before completing this form, please read notes on the back. Print in BLOCK LETTERS and mark with a tick where appropriate.

1. Employer details

Full name *(per policy)*

ABN | Policy No. | Telephone | Fax

Workplace size *(No. of Employees)*

Postal address

Postcode

Location address *(number, street, suburb)*

Postcode | If as above ☐

Name and location where worker employed *(depot, branch, etc)*

Business activity or profession

Name of authorised person

Position in organisation

Mobile | Telephone | Fax

Address for correspondence

Postcode | If as above ☐

2. Details of injured worker

Surname | Given name(s)

Residential address

Postcode

Date employed / / | Full-time ☐ | Part-time ☐ | Permanent ☐ | Casual ☐

Home telephone | Work telephone | Mobile

Date of birth / / | Sex Male ☐ Female ☐ | Occupation

Main tasks performed by worker

Is worker a direct employee? Yes ☐ No ☐ | If "No", explain employment relationship

Where time lost, please complete questions on rear of form. Please complete declaration on the back.

3. Rehabilitation

Does the employer have their own Return-to-work Co-ordinator? Yes ☐ No ☐

If "Yes", Name of Return-to-work Co-ordinator

Telephone | Fax

Has the worker returned to work under a Return-to-work Plan? Yes ☐ No ☐

3. Rehabilitation (continued)

Does the employer have a preferred rehabilitation provider? Yes No

If "Yes", Name of the Rehabilitation Provider

Telephone Fax

Has the worker been referred to this provider? Yes No

4. Accident/Injury details

Where did the injury happen?

During a break at work Away from work during a recess

Vehicle accident while working Travelling to or from place of employment

At work Other e.g.

Date of injury / / Time of injury am/pm Date notice given / /

Time notice given am/pm To whom was the accident reported

Address and place where injury occurred

How did the injury occur & what was the worker doing at the time?

Describe the injury/condition *(eg. laceration, dermatitis)*

Parts of body effected *(eg. left upper arm, right ankle)*

Do you query the validity of the injury/accident? Yes No If "Yes", explain why

Details of previous related injuries if known

Was First Aid provided? Yes No If "Yes", provide details

Nominated Treating Doctor's Name

Address

Postcode

Telephone Fax Email

Name and address of any witness(es)

1. Surname Given name(s)

Residential Address

Postcode

2. Surname Given name(s)

Residential Address

Postcode

5. Time lost particulars

Date worker ceased work / / Time worker ceased work am/pm

Has worker resumed work? Yes No

Has worker resumed on pre-injury duties? Yes No

Date worker resumed work / / Time worker resumed work am/pm

5. Time lost particulars (continued)

Normal "start time" on day of injury am/pm

Normal Working hours eg. 7.00am to 3.30pm Monday to Thursday, 7.00am to 1.00pm Friday.

to days

to days

Average weekly pre-incapacity hours calculated over the previous 12 months, or period of employment, if less than 12 months. Do not include overtime hours unless the overtime has been worked in a regular and established pattern. Hrs

Average weekly pre-incapacity earnings calculated over the previous 12 months, or period of employment, if less than 12 months. Do not include overtime earnings unless the overtime has been worked in a regular and established pattern. $

6. Employers obligations and declaration

The employer must:

- Give GIO notice of an injury (an injury notice) within 48 hours of becoming aware that a worker has received a workplace injury.
- If the employer fails to notify GIO within 48 hours of receiving an employee's injury notice, the employer is liable to pay the worker weekly compensation from the end of the notification time until such time that the employer gives GIO the injury notice.
- This notice to GIO may be given orally, or in writing, or in electronic form. If notification is given orally the employer must notify GIO in writing or electronically within 3 days after giving such notice.
- This form, together with the injured workers claim form, must be forwarded to GIO Canberra – PO Box 15, Woden ACT 2606 – within 7 days of receiving the worker claim form.
- A claim for weekly benefits will only be considered if accompanied by a WorkCover Compliant medical certificate providing the doctors opinion as to the causation of the injury, the relationship to the injury to employment, the diagnosis, prognosis and recommended treatment.

I *(print name, position)*

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

Signature of employer/authorised person

Date / /

The information in this document is confidential. It may contain privileged information. Disclosure of any particulars on this form to third parties may breach the Privacy Act 1988 (Cth) and is expressly prohibited by GIO General Limited without written approval by an authorised officer of GIO General Limited ABN 22 002 861 583.

GIO Workers' Compensation
ACT Claims
PO Box 15 Woden ACT 2606
Phone: 13 10 10
Fax: (02) 6282 9394
Email: gioactwc@gio.com.au