GOVERNMENT OF WESTERN AUSTRALIA
WorkCoverWA
2 Bedbrook Place
Shenton Park
Western Australia 6008
workcover.wa.gov.au

telephone 08 9388 5555
advisory services 1300 794 744
TTY 08 9388 5537

Workers Compensation and Injury Management Act 2023

APPROVED FORM [s. 496]

Workers Compensation Claim Form

In accordance with section 496 of the *Workers Compensation and Injury Management Act 2023* the approved form for making a claim for compensation under section 25(2) of the Act, other than with respect to a claim for dust disease or noise induced hearing loss, is **Workers Compensation Claim Form** in Appendix 1.

Workers Compensation Claim Form in Appendix 1 is effective 1 July 2024 and registered as WorkCover WA Approved Form CF1 – v1 [D2024/95685].

REBECCA HARRIS
A/CHIEF EXECUTIVE OFFICER

18 April 2024

APPENDIX 1

Workers Compensation and Injury Management Act 2023

Workers Compensation Claim Form

Insurer please complete

Insurer name

Claim number

ANZSIC Code

Policy number

WorkCover number

Has employer contacted medical practitioner Y ☐ N ☐

Estimated time off work:

- ☐ less than one day
- ☐ 1-4 work days (inclusive)
- ☐ 5-9 work days (inclusive)
- ☐ 10-20 work days (inclusive)
- ☐ more than 20 work days
- ☐ fatality

Date form received from employer

DATE STAMP

ANZSCO (office use only)

Employer please complete

Name of policy holder/employer: _____ ABN: _____

Trading as (if different to above): _____

Address: _____ Postcode: _____

Contact person name: _____ Phone: _____ Email: _____

Address of injured worker's usual workplace or base: _____ Postcode: _____

Major activity of workplace (eg sheep farming, plumbing): _____

Date employer received the completed claim form from the injured worker: _____

Date employer sent the claim form and Certificate(s) of Capacity to insurer: _____

Worker please complete

Surname: _____

Other names: _____

Address: _____

Suburb/City/Town: _____ Postcode: _____

Email: _____

Daytime contact phone number: _____

Occupation
(eg first class welder) _____

Main tasks/duties performed (eg welding of high pressure steam pipes)

_____

☐ full time (F) ☐ part time (P)

☐ permanent (P) ☐ temporary (T) ☐ casual (C)

Date of Birth: _____

☐ Male ☐ Female ☐ Unspecified

Preferred language:
(if not English) _____

At the time of the injury I was working as a:

- ☐ direct employee
- ☐ sub contractor
- ☐ working director
- ☐ visa worker
- ☐ contractor
- ☐ other
- ☐ employee of contractor

If other, please specify: _____

Other Employment

If more than one employer, please attach details on separate sheet

Do you have any other job? ☐ Y ☐ N If yes, please give details: _____

Employer name: _____ Phone no: _____ Hours per week: _____

Occurrence details

Attach separate sheet if more space is required

Day of occurrence: _____ Date of occurrence: _____ Time of occurrence: _____ ☐ AM ☐ PM

At what address did the occurrence happen? _____

Did you have to stop working? ☐ Y ☐ N If so when? Date: _____ Time: _____ ☐ AM ☐ PM

Were you:

- ☐ working – at your normal workplace
- ☐ working from home
- ☐ on work break – at normal workplace
- ☐ working – away from normal workplace
- ☐ on work break – away from normal workplace
- ☐ working – road traffic accident
- ☐ commuting/journey
- ☐ other duty status

Describe the occurrence. Include:

(i) What action was involved (i.e. fall, struck by object)

(ii) What object/machine/substance was involved (i.e. fumes, door frame)

(iii) The injury or disease caused (i.e. fracture, burn, abrasion)

(iv) The bodily location of the injury or disease (i.e. upper arm, eye)

WorkCover WA Staff Only

Mechanism

Agency

Nature

Bodily location

Worker please complete

Occurrence report – Describe how it happened

Attach separate sheet if more space is required

Where did the occurrence happen? (ie store room, machinery shop) _____

What were you doing at the time of the occurrence? _____

What were the normal working hours for that day? Starting time: _____ ☐ AM ☐ PM Finish time: _____ ☐ AM ☐ PM

When did you first report the occurrence? Date: _____ Time: _____ ☐ AM ☐ PM

Who did you report the occurrence to?

Name: _____ Position: _____ Phone No: _____

If you didn't report the occurrence immediately, please state the reason if any:

_____

Please provide the name and daytime contact phone number of witnesses of the occurrence:

1. Name: _____ Phone No: _____

2. Name: _____ Phone No: _____

Medical help/history – this occurrence

Attach separate sheet if more space is required

When did you first seek medical attention? Date: _____ Time: _____ ☐ AM ☐ PM

If not immediately, please state the reason: _____

Was the part of the body affected by this occurrence healthy before this occurrence? ☐ Y ☐ N

If not, please give details: _____

Is the present injury completely related to this occurrence? ☐ Y ☐ N

If not, please give details: _____

Please give details of any similar injury prior to this occurrence: _____

Name and contact details of your usual medical practitioner and any health provider who has treated you for a similar injury:

Name: _____ Address: _____ Phone no: _____

Concurrent claims

Are you claiming compensation from any other source? ☐ Y ☐ N If yes, from whom? _____

Worker's declaration

I declare that each and every answer above and the particulars contained herein or annexed hereto relating to myself and the occurrence are true both in substance and in fact to the best of my knowledge and belief. I take notice that under the *Workers Compensation and Injury Management Act 2023,* I am required to notify my employer or insurer within 7 days if I commence paid work with another employer after making a claim, or while receiving income compensation.

Sign _____ Print your name _____

Date _____

Consent authority – to be signed at the option of the worker

I authorise any doctor who treats me to discuss my medical condition, in relation to my claim for workers compensation and return to work options, with my employer and with their insurer.

I consent to my employer's insurer and its appointed service providers collecting personal information, inclusive of sensitive information such as medical information about me and using it for the purpose of assessing and managing my workers compensation claim, including determining liability and whether my claim is true. This consent extends to my employer's insurer disclosing my personal information, inclusive of sensitive information, to other insurers, medical practitioners, workplace rehabilitation providers, investigators, legal practitioners and other experts or consultants for the purpose of assessing and managing my claim. My personal information, inclusive of sensitive information, may also be disclosed as required or permitted by law. I also consent to my employer's insurer disclosing my personal details to WorkCover WA which is authorised to use this information to fulfil its functions and obligations under the *Workers Compensation and Injury Management Act 2023*. I have read all the information on this form regarding the consent authority and I consent to the Insurer dealing with my personal information in the manner described.

Sign _____ Print your name _____

Date _____

IMPORTANT: FAILURE TO PROVIDE YOUR SIGNATURE ON EITHER THE DECLARATION OR THE CONSENT AUTHORITY MAY DELAY A DECISION BY THE INSURER ON YOUR CLAIM