Workers Compensation Arbitration Service
2 Bedbrook Place
Shenton Park WA 6008 Switchboard **9388 5555**
workcover.wa.gov.au Advice and Assistance **1300 794 744**

Application for Arbitration

NOTES FOR APPLICANT

- An Application for Arbitration can only be made where a Conciliator has issued a Certificate of Outcome (s319) or the Director of the Conciliation Service has issued a Certificate stating the dispute is not suitable for conciliation (s313).
- You must lodge an application within 28 days of the issue of either certificate. If there are extenuating circumstances, you may request an extension of time to lodge an application by completing the **Application to Extend Time to Make an Application for Arbitration** form instead.
- WorkCover WA provides an electronic document system (EDS) for the lodgement of applications and documents related to disputes called **WorkCover WA Online**. Unless a party is exempt from using the EDS, all documents must be lodged via WorkCover WA Online. Exempt parties can also use the EDS if they wish. Registration as a user of WorkCover WA Online is easy and can be done via our website
- Further information is available in the **Guide to the Workers Compensation Arbitration Service** and can be found on our website or by contacting WorkCover WA's Advice and Assistance line on 1300 794 744.

NON-EXEMPT APPLICANT (insurer, self-insurer, employer and/or worker, represented by a legal practitioner or authorised agent)

The Application for Arbitration must be lodged using the EDS in accordance with the *Workers Compensation and Injury Management Arbitration Rules 2024.*

EXEMPT APPLICANT (unrepresented worker or uninsured employer)

- You can register to lodge your Application for Arbitration using WorkCover WA Online *or* you can download and complete this form digitally *or* print this form, complete and sign manually.
- Once you have completed your application, we advise that you keep a copy including any supporting information for your records.
- Exempt applicants can lodge this application by:

Email	In Person	Post
arbitration@workcover.wa.gov.au	**WorkCover WA** 2 Bedbrook Place Shenton Park WA 6008 (Monday to Friday 8am to 4:30pm)	**Workers Compensation Arbitration Service** **WorkCover WA** 2 Bedbrook Place Shenton Park WA, 6008

NOTES FOR RESPONDENT

- A reply to this application outlining the grounds of dispute which are admitted and/or disputed, along with all supporting documents must be lodged within 14 days of the date this application is given unless the time is abridged or extended by order of an Arbitrator or the Registrar.

SECTION A - APPLICATION DETAILS

1. Applicant *(party who is making application, e.g. worker's name)*

2. Respondent *(party who application is against, e.g. employer's name)*

3. Lodged by *(tick relevant box)*

(Note: If there is more than one respondent the Notice of Multiple Respondents form is to be completed)

☐ Worker ☐ Employer ☐ Insurer ☐ Dependant

☐ Worker representative ☐ Employer representative ☐ Insurer representative ☐ Service provider

☐ Other *(please specify:*

4. All notices from the Workers Compensation Arbitration Service to exempt applicants are sent by email.

Indicate if the applicant's preference is to receive notices by mail. ☐

SECTION B - INJURY AND CLAIM DETAILS

Do not complete this section if the claim is solely for a psychological injury or recurrence, aggravation or acceleration thereof. Refer to Section C below.

5. Date or period within which the injury or injuries occurred

6. Date the Workers Compensation Claim Form was given to the employer

7. Workers Compensation Claim Number

8. State the nature of the injury or injuries

9. Describe the circumstances in which the injury or injuries occurred

SECTION C – PSYCHOLOGICAL INJURY CLAIM

☐ **Complete questions 10 – 14 only for claims involving the contraction of a psychological injury.**

10. State the nature of the psychological injury

11. Date or period within which the psychological injury was contracted

12. Date the Workers Compensation Claim Form was given to the employer

13. Workers Compensation Claim Number

14. Describe in summary form the acts, events or circumstances of the employment which contributed to the contraction of the psychological injury

☐ **Complete questions 15 – 19 only for claims involving the recurrence, aggravation or acceleration of a pre-existing psychological injury.**

15. State the nature of the pre-existing psychological injury

16. Date or period within which the pre-existing psychological injury recurred, was aggravated or was accelerated

17. Date the Workers Compensation Claim Form was given to the employer

18. Workers Compensation Claim Number

19. Describe, in summary form, the acts, events or circumstances of the employment which significantly contributed to the recurrence, aggravation or acceleration of the pre-existing psychological injury

SECTION D - APPLICANT'S CLAIM

Complete whichever questions of 20-24 below that apply to the above issues

Worker's application for income compensation

20. The Applicant is claiming for *(tick and complete one option)*

20.1 ☐ Period(s) for which payments are sought

20.2 ☐ Review of payments from

State the reasons a review is sought

20.3 Determination of amount of income compensation

Current amount *(if applicable)* *(per week gross)* Amount sought *(per week gross)*

20.4 Additional income compensation, date from which payments sought

☐ Copy of Statement of Social and Financial Circumstances is attached

20.5 Was a Notice advising of intention to reduce or discontinue payments received? *(Y/N)*

If ***Yes*** when was the Notice receive

☐ Copy of the Notice to Worker of Intention to Discontinue or Reduce Payments is attached

Worker's application for medical and health expenses

21. The Applicant is claiming for

21.1 ☐ Medical/hospital/health/other expenses *(provide specific details below)*

Date	Nature of expense	Name of Provider	Amount
		Total $	**$ 0.00**

21.2 ☐ Increase in the medical and health expenses general limit amount

☐ Copy of Statement of Social and Financial Circumstances is attached

Employer's application for reduction or discontinuance of income compensation

22. The Employer is claiming for *(tick and complete one option)*

22.1 ☐ Reduction sought from *(present gross per week)* *(gross per week)* from

22.2 ☐ Discontinuance from

State the reasons for reduction or discontinuance

Dependancy *(complete only if claiming compensation after death of the worker)*

Note: If the worker's death occurred on or after 1 July 2018, complete the Application for Arbitration-Workplace Fatality Compensation.

23. List the dependants

Name	Date of birth	Relationship to worker	Wholly/partially dependant

23.1 Specify the section under which compensation is claimed

Other *(for example, disputes as to degree of permanent impairment or rehabilitation or recovery of payments)*

24. Specify the nature of the dispute and the orders sought

SECTION E - ISSUES IN DISPUTE

25. These proceedings were not resolved by conciliation, therefore attached is either *(select one option)*

☐ A copy of the Certificate of Outcome (s319) ☐ A copy of the Certificate of Unsuitability (s313)

26. Specify the issues remaining in dispute following the Application for Conciliation which require arbitration

27. Additional issues NOT included in the Application for Conciliation are
(The Arbitrator will advise whether these issues will be included in the scope of the arbitration of this application)

SECTION F - SUPPORTING DOCUMENTS AND INFORMATION

28. List the documents and information attached to this application

Medical documents	Author/Doctor	Specialty *(e.g. Orthopedic)*	Date of document

Non-medical documents	Author	Date of document

29. List the documents and information you intend to use but do not yet have *(not applicable for applications under sections 68, 146, 181)*

Medical

Nature of Evidence	Author/Doctor	Specialty	Reason not available	Expected Date

Non-medical

Nature of Evidence	Author	Intended use	Reason not available	Expected Date

SECTION G - PARTY DETAILS

30. Worker details

Title		Given names		Surname	
Gender		Date of birth		Occupation	
Postal address					
City/Suburb		State		Postcode	
Phone				Mobile	
Email					
Interpreter required? Y/N		Language/dialect			

31. Worker representative's details *(if represented by a legal practitioner or authorised agent - complete if known)*

Company name			
Contact person		Reference *(if known)*	
Phone		Mobile	
Email			

32. Employer details

Employer name					
Contact person					
Postal address					
City/Suburb		State		Postcode	
Phone				Mobile	
Email					

33. Employer representative's details *(if represented by a legal practitioner or authorised agent - complete if known)*

Company name			
Contact person		Reference *(if known)*	
Phone		Mobile	
Email			

34. Insurer/Self-insurer details

Company name			
Contact person		Reference *(if known)*	
Phone		Mobile	
Email			

35. Insurer/Self-insurer representative's details *(if represented by a legal practitioner or authorised agent - complete if known)*

Company name			
Contact person		Reference *(if known)*	
Phone		Mobile	
Email			

SECTION G - PARTY DETAILS *continued*

36. Other party details *(if other parties are involved in the dispute)*

☐ Service provider ☐ Dependant ☐ Other *(please specify)*

Company name					
Contact person					
Postal address					
City/Suburb		State		Postcode	
Phone		Mobile			
Email					
Interpreter required (Y/N)		Language/dialect			

37. Other party representative's details *(if represented by a legal practitioner or authorised agent)*

Company name			
Contact person		Reference *(if known)*	
Phone		Mobile	
Email			

SECTION H - SIGNATURE OF APPLICANT

Signature

	Name	
	Date	