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

Application for Conciliation

NOTES FOR APPLICANT

- Before you lodge an application for conciliation, you are required to make reasonable attempts to resolve the dispute with the other party. This generally means that you must show you have contacted the other party about the issues in dispute and their position about the dispute has been communicated to you. Submit evidence about your attempts to resolve the dispute with your application.
- 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 Conciliation 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)

An application for conciliation must be lodged using the EDS in accordance with the *Workers Compensation and Injury Management Conciliation Rules 2024.*

EXEMPT APPLICANT (unrepresented worker or uninsured employer)

- You can register to lodge your Application for Conciliation 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 your Application for Conciliation by:

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

SECTION A - APPLICATION DETAILS

1. **Applicant**

(party who is making the application, e.g. worker's name)

2. **Respondent**

(party who the application is against, e.g. employer's name)

The Applicant is the *(tick relevant box)*

- ☐ Worker
- ☐ Employer
- ☐ Insurer
- ☐ Other *(please specify)*

The Respondent is the *(tick relevant box)*

- ☐ Worker
- ☐ Employer
- ☐ Insurer
- ☐ Other *(please specify)*

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

3. Lodged by *(tick relevant box)*

- ☐ Worker
- ☐ Employer
- ☐ Insurer
- ☐ Dependant
- ☐ Worker representative
- ☐ Employer representative
- ☐ Insurer representative
- ☐ Service provider
- ☐ Other *(please specify)*

4. All notices from the Workers Compensation Conciliation Service to exempt applicants are sent by email. If the exempt applicant's preference is to receive notices by mail, tick the mail box. Mail ☐

SECTION B - INJURY AND CLAIM DETAILS

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

6. What is the injury or are the injuries?

7. How did the injury or injuries occur?

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

9. Workers compensation claim number *(if known)*

SECTION C - DISPUTE DETAILS AND OUTCOME SOUGHT

10. Identify what type of dispute this application relates to by ticking the relevant box(es):

- ☐ Determination of liability (e.g. acceptance of claim)
- ☐ Non-payment of income compensation (e.g. wages)
- ☐ Non-payment of medical and health expenses
- ☐ Non-payment of miscellaneous expenses
- ☐ Adjust income compensation
- ☐ Discontinue or suspend income compensation
- ☐ Non-payment of provisional payments
- ☐ Response to a notice to continue income compensation
- ☐ Additional income compensation *(Attach Statement of Social and Financial Circumstances form)*
- ☐ Increase in the medical and health expenses general limit *(Attach Statement of Social and Financial Circumstances form)*
- ☐ Degree of permanent impairment
- ☐ Requirement to participate in workplace rehabilitation
- ☐ Requirement to participate in a case conference
- ☐ Compensation to dependants for death of a worker prior to 1 July 2018
- ☐ Other (please specify)

11. What is the outcome you are seeking from the dispute(s) identified above in question 10?

SECTION D - ATTEMPTS TO RESOLVE DISPUTE

Please note that this section must be completed.

12. What attempts have been made to resolve the dispute?
(Include the dates of communication, the names of the people or parties involved, and any action taken to resolve the dispute prior to lodging this application. Attach copies of emails, letters, file notes, screen prints etc. to support your application).

SECTION E - PARTY DETAIL

13. Worker details

Title		Given names		Surname	
Gender		Date of birth		Occupation	
Postal address					
City/Suburb		State		Postcode	
Phone			Mobile		
Email					
Interpreter required? Yes/No		Language/dialect			

14. 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			

15. Employer details

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

16. 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			

17. Insurer/self-insurer details

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

18. 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 E - PARTY DETAILS *continued*

19. Dependant details *(only to be completed when compensation is sought by dependants following the death of a worker prior to 1 July 2018)*

Title		Given name		Surname	
Gender		Date of birth		Occupation	
Postal address					
City/Suburb		State		Postcode	
Phone			Mobile		
Email					
Interpreter required? Yes/No		Language/dialect			

19a. List of dependants *(only to be completed when compensation is sought by dependants following the death of a worker prior to 1 July 2018)*

Name	Date of birth	Relationship to worker	Wholly/partially dependant

20. Other party details

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

21. Dependant/Other party 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 F - SUPPORTING DOCUMENTS

I have attached documents supporting the application Yes ☐

(As a minimum, submit a copy of the Workers Compensation Claim Form, copies of medical certificates of capacity and medical reports, correspondence between the parties about the issue(s) in dispute and a copy of liability notices issued by the insurer or self-insurer. On particular cases, as relevant, please also submit witness statements and vouchers/accounts/receipts which apply to expenses claimed etc.)

Please note that all documents submitted will be made available to the other party or parties to the dispute,

SECTION G - SIGNATURE OF APPLICANT

	Name	
	Date	

Signature