Notification and register of injury
ACT

QBE Insurance (Australia) Limited ABN 78 003 191 035 AFSL 239 545

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Incident number

This form must be forwarded to QBE within 48 hours of a worker notifying the employer of an injury or within three days of an employer notifying QBE by telephone of an injury. Complete in block letters in the white areas and mark with a tick where appropriate.

Worker's details

	Surname	*Given name*				
Worker's name						
Home address			State	NSW	Postcode	
Telephone – home		Telephone – work		Mobile		
Email						
Date of birth	/ /	Sex: Male ☐ Female ☐				
Occupation		Industry				
Is interpreter required?	Yes ☐ No ☐	If 'Yes', please specify language				

Employer's details

Business name														
Policy number *(if known)*		ABN												
Address		State	NSW	Postcode										
Telephone		Facsimile												
Contact person for this report														
Telephone		Facsimile		Mobile										
Email		Date of notification by worker	/ /											

If someone made the notification on the worker's behalf, please provide:

Name		Telephone	

Injury details

Date of injury / / Time am ☐ pm ☐

Where did injury occur (location)?

What body part(s) were injured or affected?

What injury or disease was suffered?

How did the injury happen?

Name of witness		Position												
Address		State	NSW	Postcode										
Telephone		Mobile												

Injury details

Has the cause of the injury has been investigated? Yes ☐ No ☐

Has remedial action been taken to prevent another injury? Yes ☐ No ☐

Has the worker returned to work? ☐ Yes – normal duties ☐ Yes – suitable duties ☐ No – time lost to date ____ days

If worker has not returned to work, what is the date of expected return to work? / /

Treatment details

Did injured person give notice of injury? No ☐ Yes ☐ – If 'Yes', by whom

Was referral made for other treatment? No ☐ Yes ☐ – If 'Yes', by whom

Name of treating doctor

Address | State NSW | Postcode

Is a medical certificate available? No ☐ Yes ☐ – If 'Yes', please return with this form

Has remedial action been taken to prevent another injury? Yes ☐ No ☐

Medical authority

I give permission for any medical practitioner or authority to give information relevant to this claim to my employer's Insurer or ACT WorkSafe.

I agree that a photocopy of this authority shall be as valid as the original. I agree that while I am receiving weekly payments of compensation, I will notify my employer's insurer if:

- I start employment with some other person
- I start my own business
- There are changes in my employment affecting my earnings.

Signature X Date / /

Declaration

Privacy legislation protects personal and sensitive information on this form that could reasonably identify you to another person. QBE will only use or disclose our personal information for purposes that would reasonably be expected during the claim process. We may need to share your information with our agents or service providers who may also be involved with your claim. This could include rehabilitation providers, medical practitioners, investigators, solicitors, other insurers, and national and overseas reinsurers. If we need to use the information for another purpose, we will ask you for your permission first. You will be provided with the opportunity to access your personal information (some restrictions and costs may apply). In respect of any complaint that you may have regarding your personal information, QBE will provide you with our dispute resolution procedures. If you would like any further information or if you have any concerns about how QBE is managing your personal information, please contact the Compliance Manager by email: compliance.manager@qbe.com or by telephone: 02 9375 4656.

Name of person registering injury details

Position

Signature X

Date / /

Please return this form immediately to QBE Workers Compensation at mywcclaim@qbe.com.

Internal use only

Received by

Date / /

Time am ☐ pm ☐

Case Manager

Claim number