Employers Mutual NSW Limited

Agent for the NSW WorkCover Scheme ABN 83 564 379 108 GST Branch No 005

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Since 1910
Employers Mutual

Initial notification of injury - Fax Form

Notification No.

This form is to be used if an employee suffers a work-related injury and has not completed a claim form. This form should also be completed where any injury is significant (worker partially or totally incapacitated for more than 7 days). The shaded areas must be completed to be considered an "initial notification". Please supply as much information as possible to allow us to make payments and develop an injury management plan.

1 Employer's Particulars

Employer Name*
Policy No.
Business Address**
Post Code
Workplace Address***
Post Code
Contact Name
Phone
Contact Email
Fax
Nominated Rehab Provider
Significant Injury Yes No

*include trading name or cost centre where applicable **if policy no. unknown ***if different from business address

2 Worker's Particulars

Worker's Name
Sex Male Female
Address
Post Code
Phone
Permanent Casual
DOB
Interpreter No Yes Language
F/T P/T
Occupation
Hrs/Week
Main tasks
Award Rate $

3 Injury Details

How injury occurred
Injury Date
Details of injury
Injury Time
Accident Location
Date Employer Notified of Injury
Treating doctor or Hospital (if admitted)
Phone
Dr/Hosp Address* *if phone. unknown
Fax*
Medical Certificate from D D / M M / Y Y to D D / M M / Y Y Incapacity Total Partial
Second Injury No Yes Date Ceased work D D / M M / Y Y Expected RTW date D D / M M / Y Y
Claim Lodged No Yes Date RTW Partial D D / M M / Y Y Date RTW normal D D / M M / Y Y
Comments
Notifier's Name
Contact No
Relationship to worker Worker Employer Other-specify

Office Use Only

Criteria Met 1 - Min identifying information 2 - Medical information 3 - Injury work related 4 - Worker is a worker

Claim Forms Posted No Yes Injury on Journey form required No Yes