



WorkCover



Agent for the NSW WorkCover Scheme

ABN: 83 564 379 108/002

GPO Box 5429 Sydney NSW 2001

Ph: 1300 130 664 Fx: 1300 130 665 (General)

Fx: 02 9390 6633 (Direct line to first report)

Claimant Name

Date of Injury

 / /

Claim no.

WORKERS COMPENSATION ACT 1987

OTHER WORK RELATED INJURIES CLAIM FORM

This supplementary information is to be provided by:

- a) A worker in respect of:
 - an injury received while on the daily or other periodic journey between the worker's place of abode and place of employment, or between the place of abode and any trade, technical or other training school, where there is a real and substantial connection between the employment and the accident
 - an injury received while on a journey between the worker's place of abode and other places referred to in section 10 (3) (c) – (g) of the *Workers Compensation Act 1987*, where there is a real and substantial connection between the employment and the accident
 - an injury received while on a journey between the worker's place of employment and other places referred to in section 10 (3) (c) – (g) of the *Workers Compensation Act 1987*
 - an injury received while away from work during an ordinary recess and for an injury involving a motor vehicle accident in the course of employment.
- b) Those parties exempt from the 2012 legislation changes (police officers, paramedics, firefighters, coalminers, emergency service workers and rescue association workers) in respect of:
 - an injury received while on the daily or other periodic journey between the worker's place of abode and place of employment or to any trade, technical or other training school, or otherwise in the course of their employment
 - an injury received while on a journey between the worker's place of abode or place of employment and other places referred to in section 10 (3) (c) – (g) of the *Workers Compensation Act 1987*
 - an injury received while away from work during an ordinary recess and for an injury involving a motor vehicle accident in the course of employment.

Please complete this form in BLOCK letters and use a black pen.
If further space is required, attach a separate page.

Please indicate in which State you want to lodge this claim:

New South Wales Queensland Victoria

1 WORKER'S DETAILS

Family name

Given names

Date of birth

 / /

Sex

Male Female

Address

Suburb

Postcode

Phone

Mobile

Employer's name

Address

Suburb

Postcode

Phone

Fax

Email

2 JOURNEY DETAILS

Date and time of accident

Date / / Time : AM/PM

What mode of transport were you using?

eg. motor vehicle, public transport, walking, other

Where exactly did the accident occur? eg. street

Suburb

Postcode

Where were you travelling to? – eg. work, home, technical school

Where were you travelling from? – eg. work, home, technical school

Did the accident involve a motor vehicle whilst you were working?

Yes No

What time did you leave work, home, technical school?

: AM/PM

Were you on a recess or authorised break?

Yes No

What was the purpose of your journey?

What is your usual route for this journey?

Did you divert from your usual route?

Yes No

If Yes, provide details

Was there any interruption to the journey for any reason?

Yes No If Yes, provide details

Had you consumed any alcohol or drugs in the 12 hours immediately prior to the accident?

Yes No

If Yes, how much?

