THE UNIVERSITY OF QUEENSLAND
AUSTRALIA

Application for Workers' Compensation

Important information – please read before completing this form

The application for workers' compensation is an approved form under the Workers' Compensation and Rehabilitation Act 2003. However, the information contained on this page is not part of the approved form.

If you wish to claim workers' compensation for your injury/illness, please complete and sign the attached application and enclose the original Workers' Compensation Medical Certificate from your doctor.

Please forward completed claim form directly to Work Injury Management (WIM), preferably within 48 hours, and not via your Supervisor/Manager or HR. On receipt of your claim form WIM will contact your Supervisor/Manager and HR for any other details required.

Please complete the full contact details of your Supervisor/Manager below:

Name (Please print Manager's Name):

_____ **UQ Phone No.:** _____

Email: _____ **Faculty:** _____

Mobile: _____ **Organisational unit:** _____

Please note the following:

- Your application for compensation should preferably be lodged with Work Injury Management within 48 hours from the time of your injury/illness. However, the *Workers' Compensation and Rehabilitation Act 2003* states that lodgement of your Application for Workers' Compensation must be made within 6 months of the injury/illness arising. The Act also states that if your application is lodged more than 20 business days after your injury/illness arose, your entitlements may be affected.
- Please notify Work Injury Management of any change to your residential address and/or telephone number during the period of the claim.
- You must satisfactorily participate in rehabilitation for the duration of your claim.
- You must notify Work Injury Management if you take any action to claim damages. If successful in your damages claim, any amount paid as compensation is refunded against the workers' compensation claim.
- Please notify Work Injury Management in writing if you engage in a calling of any kind or when you return to work. You may be penalised if you fail to notify Work Injury Management of engaging in a calling or returning to work.

  Note: "Calling" means any activity ordinarily giving rise to the receipt of remuneration or reward including self-employment or the performance of an occupation, trade, profession, or carrying on of a business, whether or not the person performing the activity received remuneration.
- There are severe penalties for fraud or for any attempt to defraud Work Injury Management, for example by providing false or misleading information.
- The *Workers' Compensation and Rehabilitation Act 2003* specifies provisions for workers to request a review or appeal of specific claims decisions made by Work Injury Management as a self-insurer.

Work Injury Management
Enquiries: 3365 6022
Fax: 3365 7022
Email: wimteam@uq.edu.au

Application for Workers' Compensation

This is an approved form under section 132 of the Workers' Compensation and Rehabilitation Act 2003

Workers' Compensation and Rehabilitation Act 2003
Licensed Self-Insurer • 132.UQ

This form was approved by the Chief Executive Officer of Q-COMP, the Workers' Compensation Regulatory Authority, on 1 July 2003 pursuant to section 586 of the Workers' Compensation and Rehabilitation Act 2003.

WORKER MUST COMPLETE

Worker's Details

1. Preferred title (Mr/Mrs/Ms/Dr/Prof etc)

2. Surname/family name

3. Given names

4. Gender

☐ Male ☐ Female

5. Date of birth

6. Former name (if applicable)

7. Do you require an interpreter?

☐ Yes (see below) ☐ No

Language spoken

8. Present residential address

Street

Suburb/Town

Postcode

9. Postal address of the applicant
(If same as residential address write "as above")

Street

Suburb/Town

Postcode

10. Email address

11.Telephone number

home work

mobile

12. Facsimile

Employment Details

13. Please indicate if your employment status included one or more of the following at the time of your injury:

☐ an independent contractor
☐ a director of a corporation
☐ a member of a partnership
☐ a trustee
☐ a volunteer
☐ a self-employed individual
☐ employed or self-employed in any job other than the one in which you were injured

State name of organisation/employer (if applicable)

14. Were you an employee of the University at the time of the injury?

☐ Yes ☐ No (go to Q18)

15. Employee No: ☐☐☐☐☐☐☐

16. Please indicate the organisational unit and site at which you work:

Organisational Unit

Site

17. How long have you been employed by this employer?

Years ☐☐ Months ☐☐

18. What is your occupation?

19. How long have you been employed in this type of occupation?

Years ☐☐ Months ☐☐

20. At the time of your injury were you either:

(a) working temporarily in Queensland

☐ Yes ☐ No

(b) working for an interstate employer

☐ Yes ☐ No

21. Do you receive a Centrelink or other benefit?

☐ Yes (see below) ☐ No

Which benefit?

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Details of Injury

22. What is the nature of your injury?
(please be specific e.g. cut, strain, fracture etc)

23. What part of the body is injured?
(e.g. right index finger, lower back etc)

24. When did you first receive medical treatment for the injury/illness?

Date ☐☐/☐☐/☐☐

Name of Doctor / Hospital / Other

Address

25. Where did the injury happen?
(e.g. workshop floor, Physics Building, St. Lucia)

Campus

Building

Location

26. When did the injury happen? (be as specific as possible)

Day Time ☐☐:☐☐ ○am ○pm

Date ☐☐/☐☐/☐☐

27. Did the injury happen?

☐ Before work ☐ Early in shift ☐ Recess
☐ After work ☐ Middle of shift ☐ Unknown
☐ Overtime ☐ Late in shift ☐ Over a period of time

If the injury occurred on your way to or from work, please provide details. State your starting time (if on way to work) or finishing time (if on way home from work) for work that day.

Time ☐☐:☐☐ ○am ○pm

28. Was the injury reported to your employer or employer's representative?

☐ Yes (see below) ☐ No (go to Q30)

If yes when ☐☐/☐☐/☐☐ (Date)

29. Name of employer or employer's representative to whom the injury was reported

Name

Position

Telephone

30. Did you stop work because of this injury?

☐ Yes (see below) ☐ No (go to Q33)

Day Time ☐☐:☐☐ ○am ○pm

Date ☐☐/☐☐/☐☐

31. Have you returned to work?

☐ Yes (see below) ☐ No (go to Q32)

Day Time ☐☐:☐☐ ○am ○pm

Date ☐☐/☐☐/☐☐

In what capacity (e.g. full-time, part-time, suitable duties program)

32. Do you receive a benefit from your superannuation or private health fund?

☐ Yes (see below) ☐ No

Details

33. Explain what you were doing at the time of injury and how the injury happened (continue on supplementary page if necessary)

34. Was the injury/event witnessed by anyone? If yes, please provide witness details.

Witness 1

Witness 2

Witness 3

Witness 4

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35. Was there any object or any other person involved in the event that caused your injury.

☐ Yes (see below) ☐ No

Details

36. Was a motor vehicle/s involved?

☐ Yes ☐ No

(If yes provide details)

37. Have you previously claimed workers' compensation in Queensland?

☐ Yes (see below) ☐ No

Name of employer

Details of injury

Date of injury (approx)

☐☐/☐☐/☐☐

38. Have you previously suffered any similar injury or condition?

☐ Yes (Provide Details) ☐ No

39. Have you claimed workers' compensation outside Queensland for a similar injury or condition?

☐ Yes (see below) ☐ No

Details

Worker statement

Please read the following statement before signing this application.

In making this application for compensation, I have read the Important Information on the front page and I acknowledge that:

- It is an offence against the *Workers' Compensation and Rehabilitation Act 2003* to make a statement that is false or misleading.
- I must not engage in any calling during the period of my claim without notifying Work Injury Management in writing within 14 days.
- I must notify Work Injury Management of my return to work.
- I am obliged to satisfactorily participate in rehabilitation if required and in the absence of reasonable excuse.
- I hereby authorise any doctor, health authority, allied health provider, rehabilitation provider or other insurer to disclose to Work Injury Management any information regarding my medical history relevant to this claim.

The information I have provided is true and not misleading. I agree to advise Work Injury Management should any change in employment status occur during the currency of this claim.

Applicant's signature

Print name

Date

☐☐/☐☐/☐☐

Witness's Signature

Print name

Date

☐☐/☐☐/☐☐

(This section does not form part of the approved form)

Application Checklist

A. Please ensure you have:

☐ Signed and dated this application form

☐ Attached to your application, a Q-COMP Workers' Compensation Medical Certificate giving clear details of your injury/illness

B. Have you completed an OH&S Incident Report?

☐ Yes (see below) ☐ No

Incident Report Number _____

C. Please complete and attach the following as applicable:

☐ Form No 1 – Treating Practitioner's/ Provider's Release Authority

☐ Form No 2 – Statement from witness

☐ Form No 3 – Statement of Previous Injury/Illness/ Similar Condition

☐ Form No 4 – Injury/Illness Sustained Whilst Travelling, on a Break, or involvement in a Motor Vehicle Accident

You may wish to take a copy of this application form for your records

Worker's supplementary details

Any information entered in this section should be signed and dated by the worker.

111090/19October2018

signature of worker

Date (dd/mm/yy): ☐☐ / ☐☐ / ☐☐