




This report can be used to lodge a Workers' Compensation Claim in New South Wales, Queensland, or Victoria

EMPLOYER INJURY CLAIM REPORT

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

New South Wales Queensland Victoria

1 EMPLOYER'S DETAILS

Legal name
WE CARE NURSING HOME P/L

Trading name
N/A

Employer's scheme registration number
eg. WorkCover Employer, Policy, or Employer Registration Number
1527981

Employer's reference number (your reference)
N/A

* This question is required for NSW claims
Policy period of insurance
/ / to / /

Street address
15 Clarke Street

Suburb
UPWEY

State
VIC

Postal address
PO BOX 599 UPWEY 3158

Australian Business Number
61 538 184 067

ACN/ARBN
059 415 511

Division _____ Cost Centre _____

What is the main business activity at the incident site?
NURSING HOME

Name, position, and daytime contact number of employer contact
ELAINE McDONALD
RTN COORDINATOR
9297 9026

Name and daytime contact number of the return to work coordinator (if any)
AS ABOVE

Address for correspondence relating to this claim
address
PO Box 599
UPWEY

State
VIC

Postcode
3158

Employer contact e-mail address
EDONALD@WE.CARE.COM.AU

If you have used an interpreter, what language do you speak?

When did you receive the worker's completed claim form?
02/09/09

When did you receive the worker's first medical certificate?
09/08/09

2 WORKER'S DETAILS

Family name
COOPER

Given names
ANGELA MARY

Street address
15 JOHNSTON ST

Suburb
LYSTERFIELD

Postcode
3156

Daytime contact phone number/s
MOBILE 332800 | W 9297 9000 | H 929 3015

Date of birth
28/09/79

Gender
 Male Female

3 WORKER'S EMPLOYMENT DETAILS

Street address of the worker's usual workplace
15 CLARKE ST
UPWEY

Suburb
AS ABOVE

State
VIC

Postcode
3158

* This question is required for NSW claims
How many workers are employed at this workplace?

This question is required for Victorian claims
Workplace number for worker's usual workplace
3588926

If the incident did NOT happen at one of your workplaces, please give the name of the employer responsible for the workplace
Employer's name
N/A

What is the worker's usual occupation?
KITCHEN HAND

What are the main tasks performed by the worker in their usual occupation?
PREPARING MEALS
DELIVERING MEALS TO RESIDENTS
PICK UP TRAYS & LOAD ONTO TRUCKS

Which of the following apply to the worker?
(Please tick all relevant boxes)

Casual Student
 Full-Time Part-Time Apprentice Volunteer
 Contract Trainee Agency worker Contractor
 Permanent Temporary Seasonal Jockey

Other? *

When did this worker start working for you?
25/06/07

* These questions are required for NSW and QLD claims
Is the worker employed under any of the following?
 Federal award Registered industrial agreement
 State award No agreement or award
 WCA Jobcover Program Registered enterprise agreement

* What is the title of the award or agreement?

What is the worker's minimum weekly wage?
As specified by the award or agreement \$540

4 WORKER'S RETURN TO WORK DETAILS

If the worker has returned to work, please provide the date
/ / NO RTW

What duties are they doing? Full Suitable/Modified

Don't forget your WorkCover Employer Number (WEN)

Don't forget the workplace number to ensure the claim is registered against the correct workplace.

These dates should match with Section 7 of the worker's claim form

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How many hours do they work each week? hrs

How many days have been lost? days hrs

Have you provided the worker with a return to work plan, taking into account the injury/condition?
 Please attach a copy of the return to work plan or agreement, or please explain why you have not provided a plan.

If the worker has not returned to work, do you know of any issues that would delay or prevent a return to work?

5 CLAIM CONFIRMATION DETAILS

Do you agree that the details provided in sections 2 & 4 of the Worker's Injury Claim Form are correct? Yes No

Do you accept that your worker has an injury/condition which is work-related and occurred while in your employment? Yes No

Note: If you agree the injury is work-related, and believe that the details provided in sections 2 & 4 of the Worker's Injury Claim Form are correct, you do not need to complete the remainder of this form except for section 9, which MUST be completed. Otherwise, please complete any relevant questions in sections 6, 7 and 8 of this Report.

6 WORKER'S EARNING DETAILS

Please complete this section if you wish to claim for weekly payments

How many standard hours did the worker work each week before being injured? Exclude overtime hrs

What were the worker's usual working hours?
 For example, Monday to Friday, 8.30 am to 5.30 pm

What was the worker's usual gross hourly rate? \$

Exclude overtime & shift allowances

What was the worker's usual gross weekly earnings? Exclude overtime & shift allowances \$

Please provide details of any overtime or shift work

Average weekly overtime hrs \$

Weekly shift allowance \$

Please provide payroll records covering the 12 months prior to injury

7 INCIDENT DETAILS

What is the worker's injury/condition, and which parts of the body are affected?

What happened and how was the worker injured?

What is the street address where the incident occurred?

Suburb

State

What date and time did the injury occur?
 AM

What date and time did the worker first cease work?
 AM

Which of the following incident circumstances apply?

While working at the usual workplace

While working away from the usual workplace

During a meal-break or authorised recess at work

While away from work during a recess

Travelling to or from work*

A motor vehicle accident while working*

* For NSW incidents a journey claim form must also be completed

If the injury was the result of driving or using a motor vehicle or the use of public transport, please provide the registration number/s of any vehicles involved

State

Has the worker had a similar injury/condition or personal injury claim before that relates to this injury/condition?
 Please give details, including claim numbers

When did the worker report the injury to you?

Who was the injury reported to?

What are the names and daytime contact details of any witnesses?

Do you believe that the injury/condition was caused or contributed to by the worker, or a third party such as a manufacturer or supplier? Please give details if relevant

8 ADDITIONAL INFORMATION

Do you want to provide any additional information that may assist in the determination of liability or the management of this claim? eg. Do you dispute liability, and, if so, why?

9 EMPLOYER'S DECLARATION

I have read the information provided in this form. I declare that the information I have supplied in this form, and any attachment to this form, is true and correct and that no information has been suppressed or omitted from this report to the best of my knowledge. I understand that the making of a false or misleading statement concerning a claim is punishable by law and that I may be prosecuted.

Signature of employer's representative Date

Name

Position

ORIGINAL