SECONDARY INJURY APPLICATION FORM

Once you have completed the Secondary injury claim application please e-mail to NTreturnTowork@gbtpa.com.au

An Eligibility Officer will be allocated to commence investigations on this application. Investigations may include obtaining doctors medical reports inclusive of clinical notes, attendance at an Independent Medical Examination, etc.

The Eligibility Officer will contact you within 3 business days of receiving this application regarding what (if any) further medical information is required. If there is any information you would like us to consider when reviewing your claim, please provide this to us as soon as possible.

First name and Surname	
Date of Birth:	
Home address:	
Postal address:	
Mobile number:	
Work number:	
Injury:	
Date of Injury:	
Claim number (maximum of 9 characters):	

Factors and incidents *(Please identify all factors and events that you believe have caused or contributed to your injury which will best support your claim. It is important that you provide details of how your injury happened or what caused the disease, please include dates.)*
Current Symptoms and treatment *(Please describe the symptoms you are currently experiencing and when the symptoms start)*

Injury *(Part(s) of body affected)*
GP Details *(Name of GP, Address and Phone number)*
Work capacity - (Are you currently working? Are working with the same employer where your original injury occurred? If you are working, please stipulate the hours per week and days per week that you are working?)
Pre-existing conditions (*Have you previously sought treatment for a similar injury/condition with a GP, Psychologist or Psychiatrist? If yes, please provide their details below and advise of the date you first saw them)*
Please complete Medical Authority form *(To obtain medical information from your treating doctor we require a signed Medical Authority from you to do so.)*

9. Workers authority to release medical and relevant personal information and declaration

This authorisation and declaration must be signed or your claim will not be considered by the insurer

I authorise and consent to any person who provides me with a medical or hospital service, if requested by my employer or their insurer or the employer or insurer's appointed service providers, for the disclosure and release of information regarding the service that is relevant to the injury or disease for which I have made a workers compensation claim.

This authorisation and consent extends to the collection, disclosure and release of any health and related personal information that is relevant to the injury or disease for which I have made a claim, by my employer or their insurer or the employer or insurer's appointed service providers, including the disclosure and release of such information to each other, and/or to one or more of the following: the Work Health Authority (NT WorkSafe), a legal practitioner, medical practitioner, investigator, accredited vocational rehabilitation provider, or any other person reasonably consulted by the employer or insurer for making a decision as to payment of the claim for compensation.

I consent to NT WorkSafe using the information collected in connection with my claim to fulfil its obligations under the *Return to Work Act* or for the purposes of research about workers compensation, workplace injury management and work health and safety.

I understand that if this claim results in my receiving weekly compensation payments, I am required to notify the party paying my benefits if I commence employment with some other person, and that failure to do so is an offence.

I have read the information provided in this form. I declare that the information supplied in this form, and any attachments to this form, is true and correct to the best of my knowledge. I understand that making a misleading statement or giving a document that contains misleading information is an offence.

Other than your signature, please complete all fields in this section using printed ALL CAPITAL letters

First Name:		Surname:	
Date of birth:		Date of injury:	
Type of injury or disease:			
Signature:			

Date that claim form forwarded to employer: Posted ☐ By hand ☐ Emailed ☐

9A. If you are completing this claim form for the injured or diseased person, complete:

Name:		Address:			
Suburb:		State:		Postcode:	

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Declaration:

I have read the information provided with this form. I declare that the information supplied in this form, and any attachments to this form, is true and correct to best of my knowledge. I understand that making a misleading statement or giving a document that contains misleading information is an offence.

I agree to advise Gallagher Bassett if my circumstances change or if I become aware of any matter that would make the above information false or misleading.

Signature ..... **Date** .....