



**SECTION C: INJURED PERSON'S DETAILS: To be completed for any injury to an employee, student or visitor.**

Name of Injured person:		Date of Birth:
Residential address:		
Home Phone Number:	Work Phone Number:	
Mobile Phone Number:	Email address:	
Injury Reported to:	Date reported:	
Initial treatment given by:		
<input type="checkbox"/> First Aid Officer (name): ..... <input type="checkbox"/> Other (details) .....		

**SECTION D: INJURED EMPLOYEE DECISION ON CLAIMING WORKERS COMPENSATION**

<b>For all injuries to employees please tick one of the following:</b>	
<input type="checkbox"/>	<b>NOTIFY AS AN INCIDENT ONLY:</b> <i>At this time I do not wish to lodge a claim for workers compensation for this incident and take personal responsibility for any medical expenses and sick leave associated with this matter.</i>
<b>OR</b>	
<input type="checkbox"/>	<b>NOTIFY AS A WORKERS COMPENSATION CLAIM:</b> <i>I wish to lodge a claim for workers compensation for medical expenses and time off work associated with this injury or illness. Please complete Section E below. The insurance company will mail claim forms to the above address</i>

Sections A, C & D must be completed and copied or faxed to OHS & Injury Management within 24 hours (fax 9351 5868).

**SECTION E: REQUIRED FOR EMPLOYEE TO BEGIN A CLAIM FOR WORKERS COMPENSATION**

<p>1. A NSW Workers Compensation Medical Certificate must be submitted to OHSIM for all claims as soon as possible by fax on 93515868 or by mail to OHSIM, K07, University of Sydney, 2006.</p> <p>2. NSW legislation limits wages claims to a maximum of \$1621.60 gross per week. Staff who earn over this amount will incur a wage loss until they resume full working hours.</p>			
Employment Status: <i>tick one</i> <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Casual		Date Commenced Employment:	
Award Wage Rate per week (gross):		Award Hours per week:	
Average Weekly earnings: <i>(for casual staff only)</i>		Average Hours per week: <i>(for casual staff only)</i>	
Date Ceased work:		Time ceased work:	
Current work status: <i>tick one</i> <input type="checkbox"/> Unfit for work <input type="checkbox"/> Fit for pre injury duties <input type="checkbox"/> Fit for suitable duties		Date resumed work:	Lost hours to date:
Parts of Body Injured:			
Previous Related Injuries:		Marital Status: <i>tick one</i> <input type="checkbox"/> Married <input type="checkbox"/> De Facto <input type="checkbox"/> Single	Number. of Dependants:
Treating Doctors Name:			
Doctors Address:			
Doctors Phone Number:		Doctors Fax Number:	
Treatment Program:			
Current Medical Certificate Date:		Review Date:	

**Completed by:** ..... **Signed:** ..... **Date:** .....