Workers Compensation Claim Form

South Australians with a work-related injury can lodge a claim for workers compensation and may be entitled to income maintenance payments and/or reimbursement of medical expenses paid.

In this form, Paid Employees/Retained Firefighters/ Volunteers will be referred to as "the Worker".

By completing all or as many fields as you can on this claim form, you will be providing vital information that will assist in making a prompt determination on your claim.

Before making a claim, workers need to:

- **notify your agency about the injury by contacting:**

  MFS: your Officer-in-charge (Operational Staff) or Supervisor/Manager (Admin Staff)

  CFS: your Regional Office (Volunteers) or Supervisor/Manager (Paid Employees)

  SES: your District Officer or in their absence, Regional Duty Officer (Volunteers) or Supervisor/Manager (Paid Employees)

  SAFECOM: your Supervisor/Manager

  Employees: must complete a HIRM immediately or within 24 hours of injury

  CFS Volunteers: must complete Volunteer Accident Notification & Investigation to Region form

  SES Volunteers: must complete Member Notification to SES Headquarters form

- **Consult with a GP/Specialist and obtain a Work Capacity Certificate (WCC).**

How to make a claim for compensation:

Step 1: Complete this form

Wherever possible, the worker and their Agency Representative should complete this form together in the first instance.

Where a worker is unable to complete this claim form, a representative, such as a treating doctor, a worker's friend or a Return to Work Coordinator can assist the worker by completing this form with the worker's consent.

Step 2: Sign the Medical Authority on page 4

Step 3: Meet minimum requirements for making a Workers Compensation claim

- A completed Claim Form, and
- A completed HIRM, and
- A Work Capacity Certificate (WCC) as issued by a GP or Specialist.

Step 4: Lodge paperwork

Ask your agency representative listed above to promptly fax/email this paperwork to SAFECOM Injury Management for actioning (Originals must be posted afterwards):

- Fax to: 8115 3985
- Email: SAFECOM.IM@sa.gov.au
- Postal: GPO Box 2706 Adelaide 5001
- Address: Level 6, 60 Waymouth Street Adelaide

Important information for workers

> Report any work-related injury to your Agency as soon as possible.

> Talk to your doctor about work tasks you can still do and obtain a Work Capacity Certificate.

Please ensure you are issued with a Work Capacity Certificate/s only as General Sickness Certificates are not recognised under Return to Work Act 2014.

> Discuss with your Return to Work Coordinator about a plan to remain at work or return to work as soon as medically practicable.

> Be actively involved in your treatment, rehabilitation and return to work, or stay at work plans.

> **Payment of wages and/or medical expenses will not be forthcoming until minimum requirements have been met, paperwork has been lodged to SAFECOM and a determination to accept this claim has been made.**

Important information for Agencies

* This form must be submitted to SAFECOM within two business days of you receiving it.
* Immediately notifiable incidents
* It is a legal requirement under the Work Health and Safety Act 2012 for a person who conducts a business
* or undertaking to notify SafeWork SA of:
* the death of a person
* a serious injury or illness of a person including immediate treatment for amputation, serious head, eye, burn and laceration injuries, separation of skin from underlying tissue, spinal injury or loss of body function; medical treatment within 48 hours of exposure to substance;
* a dangerous incident that exposes a worker or any other person to a serious risk to a person's health or safety emanating from an immediate or imminent exposure, whether or not an injury has actually occurred and however minor.

How to claim wages when working for a business outside of the CFS/MFS/SES/SAFECOM

SAFECOM will need to contact any employer that you work for outside of the CFS/MFS/SES/SAFECOM in order to obtain wage details for determination of Average Weekly Earnings (weekly wages) if you have lost time away from other employment.

Privacy laws require that you provide to SAFECOM a signed:

- Authority to release wage information to SAFECOM
  (sign authority in Section 6C on this form)

In order to place you onto the relevant Agency Payroll, we will also require a completed and signed:

- Tax Declaration form *(available from Australia Post outlets)*
  Please note that if you tick no to claiming the tax free threshold, up to 50% of your wages may be taken in tax.
- Payroll Disbursement Form
  (available on the SAFECOM Intranet via your agency contact)

Please provide the above paperwork to SAFECOM promptly so they can contact your employer without delay for this information.

Section 1 - About this claim

1A - What is the claim for?

☐ Loss of wages ☐ Medical expenses

☐ Loss of wages and medical expenses

1B - Who is filling out this form?

When possible, it is suggested the worker and Agency Representative complete this form together.

☐ Worker ☐ Agency Representative

☐ Both worker & Agency Representative

☐ Other - Name: _____

Relationship (i.e. Family, friend or representative):

_____

Section 2 - Worker details

Family name: _____

Given names: _____

Former names (if any): _____

Title: ☐ Miss ☐ Ms ☐ Mrs ☐ Mr ☐ _____

Date of birth: DD / MM / YYYY

Gender: ☐ M ☐ F ☐ Other

Address: _____

_____

_____

Postal address: ❑ tick if same as residential

_____

_____

_____

Daytime phone number: _____

Mobile number: _____

Email: _____

(Note: Providing an email will ensure prompt receipt of important notices.)

Does the worker wish to identify as:

☐ Aboriginal ☐ Torres Strait Islander

Country of birth: _____

Does the worker need an interpreter?: ☐ Yes ☐ No

If yes, identify language (including Auslan): _____

Dialect: _____

Section 3 - Injury details

3A - Injury information

What was the circumstance in which the injury occurred: (tick one)

☐ Working at usual workplace (ie Station, Regional Office, Unit, etc)

☐ Working elsewhere

☐ Travelling to or from work

☐ Attending an approved course of study

☐ Working, had a traffic accident—Police Report Number:

☐ Having a break

☐ Other (please specify): _____

Date and time of the injury: (or when was it first noticed)

Date: DD / MM / YYYY Time: _____ am/pm

Has the worker resumed work? ☐ Yes ☐ No

If yes, date and time worker resumed:

Date: DD / MM / YYYY Time: _____ am/pm

Has the worker returned to:

☐ pre-injury hours or ☐ less than pre-injury hours

Has the worker returned to:

☐ normal duties or ☐ modified duties

3B - Where did the injury occur?

Location: _____

Address: _____

_____

Suburb / town: _____

Postcode: _____

3C - Description of the injury

What is the injury and part of the body affected?
(e.g. broken left lower leg, right knee strain, lower back strain):

_____

_____

_____

What was the worker doing at the time of the injury?
(e.g. walking over uneven ground and twisted knee, lifting sandbags, etc):

_____

_____

_____

_____

What happened and how was worker injured?
(e.g. repeatedly lifting heavy bags causing lower back pain):

_____

_____

_____

_____

Section 4 - Capacity for work and treatment

4A - Treating doctor's information

Name: _____

Practice name: _____

Practice phone: _____

Practice address: _____

Suburb / town: _____ Postcode: _____

Hospital (if you were or are hospitalised): _____

_____

4B - Medical certificate details

Work Capacity Certificate covers the period:

from DD / MM / YYYY to DD / MM / YYYY

Section 5 - Agency details

5A - Agency's name and address

Tick one:

- ❑ CFS - GPO Box 2468, Adelaide SA 5001
- ❑ MFS - GPO Box 98, Adelaide SA 5001
- ❑ SES - GPO Box 2706, Adelaide SA 5001
- ❑ SAFECOM - GPO Box 2706, Adelaide SA 5001

Agency start date: DD / MM / YYYY

5B - Employment type

The worker is:

☐ paid employee ☐ volunteer ☐ retained firefighter

5C - Worker's main tasks with Agency

Main tasks: _____

(eg: fighting fires, road crash rescue, administration duties, etc)

Section 6 - Compensation payments

Please complete section 6 if claiming for loss of wages.

This information relates to my employment with:

Paid employees: ❑ CFS ❑ MFS ❑ SES ❑ SAFECOM

Volunteers/Retained Firefighters: ❑ Other employment

6A - Worker's employment details.

Employment status:

☐ full time permanent ☐ full time casual

☐ part time permanent ☐ part time casual

Working Hours:

What are your regular hours worked each day of the week:

Mon	Tue	Wed	Thu	Fri	Sat	Sun	Total

If you are a shift worker:

What is your regular roster?: _____

(ie 4 shifts on, 4 days off or week on, week off, etc)

Your regular weekly rostered hours: _____ hours

Section 6 - Compensation payments continued

Please complete section 6 if claiming for loss of wages.

6B - Worker's income details

Your gross weekly wage at the time of the injury? $ _____

Do you normally work overtime? ☐ Yes ☐ No

If yes, what is the average amount earned per week? $_____

What are the average hours of overtime per week? _____

Does the worker receive non-cash benefits? ☐ Yes ☐ No

If 'Yes' what is the benefit? (e.g. car, phone, computer, etc) _____

6C - Other employment details

Do you have any other current employment outside of the CFS/MFS/SES/SAFECOM:

☐ Yes ☐ No

If yes, please refer to the front page and provide a completed:

- Tax Declaration form
- Payroll Disbursement Form

For this employment, what is your:

Job Title: _____

Main tasks: _____

In order to obtain payroll information from your other employer, we will require a signed authority from you allowing your other employer to release the requested payroll information to SAFECOM for calculation of Average Weekly Earnings.

Authority to release Payroll Information

Only the worker can complete this section.

I hereby authorize my employer to release all payroll information concerning my wage earnings to the SA Fire and Emergency Services Commission (SAFECOM) in order for SAFECOM to calculate my Average Weekly Earnings prior to my accident with:

Tick appropriate Agency:

- ❑ Metropolitan Fire Service (MFS), or
- ❑ Country Fire Service (CFS), or
- ❑ State Emergency Service (SES), or
- ❑ SA Fire & Emergency Services Commission (SAFECOM).

Signed :

.....

[Worker's signature] [Date]

Other employer payroll contact details:

Name: _____

Phone: _____

Fax: _____

Email: _____

Address: _____

_____

Section 7 - EFT details

Payments and reimbursements can then bepaid by EFT

7A - Worker's Electronic Funds Transfer (EFT) details

Bank name: _____

BSB number: _____

Bank address: _____

Account number: _____

Account name: _____

Section 8 - Notification of injury

Notification details

When was the Agency notified of the injury?

Date: DD / MM / YYYY

Name of person notified: _____

Position/title of person notified: _____

Person notifying: ☐ Worker ☐ Other, please specify:

_____

Date claim form given to/completed with Agency:

DD / MM / YYYY

Section 9 - Other information

Provide any other information relevant to the assessment of the claim: _____

_____

_____

_____

_____

Important information—read before completing sections 10 and 11

It is intended that the worker and Agency complete this form together. If this is the case, the Agency should complete section 10 and the worker section 11. If not, only the person (worker or Agency) completing the form should sign the relevant section.

Section 10 - Agency declaration

I acknowledge that it is an offence against the Return to Work Act 2014 to make a statement that is false or misleading. The information I have provided is true and not misleading. I agree to advise SAFECOM:

- if the circumstances change
- if I become aware of any matter that would make the above information false or misleading
- of any change in the worker's return to work status.

Agency representative name: _____

Position: _____

Signature: _____

Date signed: _____

Section 11 - Medical authority & worker declaration

Only the worker can complete this section.

I give permission for my medical experts to provide SAFECOM with information relating, and/or relevant, to my work injury, condition or illness.

I also give permission for any of my medical experts to receive x-rays, medical records or reports relating to my claim (including copies) for the purpose of writing a report about my injury, condition or illness related issue.

I give permission for SAFECOM to release my personal contact information to an independent medical examiner for the purpose of an appointment reminder. A photocopy of this medical authority is valid.

I acknowledge that it is an offence against the Return to Work Act 2014 to make a statement that is false or misleading. The information I have provided is true and not misleading. I agree to advise SAFECOM if my circumstances change or if I become aware of any matter that would make the above information false or misleading. I will advise SAFECOM if I undertake any employment (paid or unpaid), including self-employment, during my claim.

Worker's full name: _____

Worker's signature: _____

Date signed: _____

Next Steps

When SAFECOM receives this completed claim form, Work Capacity Certificate/s (WCC/s) & completed HIRM they:

- may request additional medical information such as treating medical reports, arrange for an independent medical examination, witness statements, etc to assist in making a fair and reasonable determination on your claim.
- may request additional information such as payroll information to assist in determining the rate of weekly payments.
- will assess the claim on the information to hand and then seek approval from the relevant Agency to make a determination to accept or reject the claim for compensation.
- will remain in contact the worker throughout the life of the claim.

Please keep a copy of this completed form for your records.