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Employer's Recurrence Report of Injury and Notification Form

This form is to be completed by the employer for a recurrence of an original injury / illness, after duties have been resumed.

This form must be submitted to and signed off by your employer.

1. Employee Details

Name _____ Claim number ☐☐☐☐☐☐☐☐☐☐☐☐

Date of original injury / / Employer at date of original injury _____

Date of recurrence / / Date returned to duties / /

2. Recurrence Details

1. Are you aware of any treatment the employee was receiving prior to the recurrence? ☐ Yes ☐ No

   If Yes, please specify _____

2. When the employee returned to duties, were you aware that they were experiencing any discomfort or symptoms as a result of undertaking those duties? ☐ Yes ☐ No

   If Yes, please specify _____

3. What was the employee doing at the time of the reported recurrence?

4. In your opinion, how does this recurrence relate, if at all, to the employee's original injury?

5. In your opinion, is discomfort / symptoms in the same part of their body as the original injury? ☐ Yes ☐ No

   If Yes, please specify _____

6. In your opinion, are there any other circumstances that should be considered in determining this as a recurrence of the original injury? ☐ Yes ☐ No

   If Yes, please give details _____

3. Employer Declaration

I (print name and position) _____
declare that the details above are true and correct in every particular.

Employer signature _____ Date / /

EML ABN 67 000 006 486 Level 3, 345 George Street, Sydney NSW 2000, GPO Box 3228, Sydney NSW 2001
T: 02 8071 3400 T: 1800 365 401 (toll free) F: 02 8251 9495