Public Sector Workers' Compensation Claim Form

This form is to be completed if you wish to claim workers' compensation under the *Safety, Rehabilitation and Compensation Act 1988* (SRC Act), an Act relating to the rehabilitation of employees and to workers' compensation for those employees.

Sections of this form are to be completed by you and your employer. If you have difficulty completing this form, please seek assistance from your employer. For the purposes of this form, 'employer' refers to your supervisor, line manager or directorate/agency HR area. EML is the ACT Government's workers' compensation Claims Manager. Further information can be found on the ACTPS Employment Portal.

How to claim

- If you have not already told your employer that you have been injured or contracted an illness at work, notify them as soon as possible. You must also complete a WHS incident report.
- Complete this form together with your employer or, once you have answered the questions, give this form and any attachments to your employer. Your employer will then complete their section and and submit it to the Injury Management Team, Work Safety Group, CMTEDD.
- If you are no longer employed by the ACT Government, you must complete and give the form and attachments to the HR area of the directorate/agency you were employed with when you were injured.
- If your answers do not fit in the space provided, please attach additional pages where necessary.

Attachments you must supply

Your claim cannot be assessed unless you attach:

- A *Certificate of Capacity* with a medical diagnosis, clarifying what caused your condition, your capacity for work and a description of your condition and symptoms. The document is completed by your doctor or medical specialist.
- If you are claiming for a psychological injury you must attach a statement outlining the events that contributed to your injury in support of your claim.
- If you are only claiming for chiropractic, physiotherapy, dentistry or osteopathic treatment and not for time off work, you only need to provide a medical certificate from your treating chiropractor, physiotherapist, dentist or osteopath.
- A separate *Journey form* must also be completed if your injury happened while travelling for work purposes.
- You can find these forms and more information on the workers' compensation page of the ACTPS employment Portal.

If you need more information

- Contact your directorate/agency HR team or supervisor or line manager.
- Contact the Work Safety Group Injury Management team by email to injurymanagement@act.gov.au or call (02) 6205 4519.
- For information about lodging a claim you can visit the ACTPS Employment Portal or www.eml.com.au.
- For translating or interpreting assistance, call 13 14 50.
- The ACT Work Rehabilitation Policy provides information on rehabilitation in the ACTPS.

Responsibilities

Your responsibilities

- Actively engage with your employer and/or your rehabilitation case manager to facilitate your return to work and health.
- Actively participate in your rehabilitation.
- Provide the case manager with timely, accurate and complete information about your claim.
- Cooperate and communicate regularly with your employer and rehabilitation case manager about your claim.
- Advise the Claims Manager, rehabiltation case manager and employer as soon as possible about any changes in your circumstances.

Employer's responsibilities

- Assist with your rehabilitation and encourage early and safe return to work.
- Maintain contact with you whilst you are absent from work and when you return to work.
- Work with you to identify and find suitable work or support a gradual return to work where a return to normal duties is not possible.
- Talk with your medical practitioner, workplace rehabilitation provider or other health professionals to understand what jobs/tasks you can safely do at work.

Rehabilitation Case Manager's responsibilities

- Assist with your rehabilitation and encourage early and safe return to work.
- Work with you to identify modified/alternate duties where a return to normal duties is not possible.
- Liaise with your treating doctor to understand what jobs/tasks you can safely do at work.
- Assess whether rehabilitation is needed and appoint a workplace rehabilitation provider if required.
- Provide rehabilitation and return to work support to both you and your employer.

The claims administrator's responsibilities

- Work with you, other stakeholders, including your treating doctor to get you back to health, and work.
- Notify you of any decisions and entitlements for your claim.
- Deliver appropriate and timely management of your claim, including payment for your treatment and time off work where appropriate.

Privacy statement

The Australian Capital Territory (represented by the Work Safety Group, Chief Minister, Treasury and Economic Development Directorate (CMTEDD) collects, uses and discloses your personal information for the purposes of, or under, the SRC Act. CMTEDD collects personal information that is reasonably required to manage your workers' compensation claim, any associated rehabilitation or to comply with regulatory requirements under the SRC Act and the *Work Health and Safety Act* 2011 (WHS Act).

If CMTEDD is unable to collect, use and disclose your personal information for the purposes of assessing your claim made under the SRC Act or for related functions, we may not be able to determine or progress your claim. CMTEDD may also need, in accordance with the *Information Privacy Act 2014*, and the *Health Records (Privacy & Access) Act 1997* (ACT), to collect your personal information from, and disclose your personal information to, a number of parties, including the following:

- Any Claims Manager appointed by CMTEDD, including its contractors, consultants, or advisors
- your employer (including any relevant managers) when you were injured
- your current employer and any subsequent employer
- your superannuation fund manager or trustee
- legal advisors
- your rehabilitation case manager
- officers delegated to assist in your recovery and return to work
- your workplace rehabilitation provider
- vocational and functional assessor
- any health professional, hospitals, other health institutions, or service providers related to your claim
- the EML Group (including EML Solutions Pty Ltd)
- law enforcement authorities
- Comcare
- The Safety, Rehabilitation and Compensation Commission (SRCC)
- personnel engaged by CMTEDD, Comcare or the SRCC to conduct research-related activities
- Medicare and Centrelink
- inspectors appointed under section 156 of the WHS Act
- CMTEDD
- any relevant third party for the purposes of assessing, administering, managing, responding, or dealing with your claim or any matters connected with your claim.

It is unlikely CMTEDD will provide personal information to anyone in an external territory or outside Australia, unless the information relates to an incident, investigation, injury or illness sustained while overseas, or treatment provided by an overseas or interstate practitioner. If disclosure of personal information is made to someone overseas, CMTEDD will follow the Territory Privacy Principles that relate to disclosure to overseas entities.

Accuracy of personal information: CMTEDD wants to ensure personal information is up to date and complete. Our Privacy Policy explains how to access personal information held about you and how to go about making any corrections. The Privacy Policy can be found on the CMTEDD website.

Complaints: if you think CMTEDD has interfered with or breached your privacy (contrary to the requirements of the *Information Privacy Act 2014/Health Records (Privacy & Access) Act 1997*), our Privacy Policy contains information about what you should do and how we will respond. For a copy of our Privacy Policy, to request a change of your personal information or to make a privacy complaint visit the CMTEDD website.

Claims Manager: as a self-insured licensee, the ACT Government may appoint a Claims Manager to provide delegated claim administration services in accordance with the licence issued by the SRCC.

From 1 March 2019 the Employers Mutual Limited (EML) including EML Solutions Pty Ltd have been appointed as the ACT Government's workers' compensation Claims Manager. Further information regarding EML can be found on the ACTPS Employment Portal or by visiting eml.com.au.

Authority for consent, use and disclosure

I declare that:

1. I have read and agree to all the information within this form including the privacy statement.
2. The information I have supplied on this form and any other attachment is true and accurate.
3. I am aware that I must advise CMTEDD and the delegated claims administrator immediately if I engage in any employment, whether paid or not, or in the running of a business in my own right or as a partner during the period I am absent from work as a result of this injury and/or disease.
4. I am aware that I must advise CMTEDD and the delegated claims administrator if my injury or disease improves during any period of incapacity sufficiently to allow me to return to work.
5. I understand if I withdraw my consent then this may result in my claim being suspended or cancelled.
6. I am aware that the making of a false or misleading claim or false or misleading statement in support of that claim is punishable by law, including under the *Criminal Code 2002* and, in the event, I may be liable for prosecution.
7. I am aware that any monies paid by or on behalf of CMTEDD as a result of a false or misleading statement or claim will be recovered.
8. I authorise and consent to the collection, use, and disclosure of my relevant personal and medical information by CMTEDD, and any relevant parties, including those listed above, for purposes connected with the assessment and management of my compensation claim, and to carry out its regulatory functions.

If you refuse or fail, without reasonable excuse, to allow CMTEDD and/or EML as the delegated claims administrator and the above parties to use and disclose your personal medical information, CMTEDD and/or the delegated claims administrator may be prohibited from dealing with your claim as the information is necessary in order to manage and determine your claim for workers' compensation, to assist with treatment and to perform other functions required by the SRC Act.

Print your name	**Signature**	**Date**

Your personal information

1. Title

2. First name(s)

3. Surname

4. Preferred name

5. Previous (Eg: Maiden name)

6. Date of birth

7. Medicare number

8. Gender

☐ Female ☐ Male ☐ Other not specified

9. Do you wish to identify as Aboriginal or Torres Strait Islander?

☐ Yes - Aboriginal ☐ Yes - Both ☐ No

☐ Yes - Torres Strait Islander

10. Preferred Contact Details

Phone	
Email	

11. Residential Address

Street	
Suburb	
State	**Postcode**

12. Postal Address (if different from above)

Street or PO Box	
Suburb	
State	**Postcode**

13. Would you prefer we communicate with you by email or post?

☐ Email ☐ Post

14. Preferred language (if not English)

15. Do you require an interpreter?

☐ Yes ☐ No

16. Position level at the time of injury or illness (e.g. ASO4, SOG-C, GSO9, RN1 etc.)

17. Please provide your current supervisor or line manager details

Name
Phone
Email
Job Title

About your injury

18. The date of the injury or illness onset (if unsure, list the first date you sought medical treatment)

Date	**Time**

19. Name of your directorate/agency when you were injured or became ill

20. Name of the supervisor or manager at the time of the injury

21. Name of workplace or area you were employed in at the time of your injury or illness

22. Where were you at the time of your injury or illness onset?

☐ Your usual workplace ☐ On a work break

☐ Working from home ☐ Other

☐ Travelling for work

☐ Working away from your usual workplace

☐ Engaged in an employer approved activity

23. If injured, where did your injury occur?

Street	
Suburb	
State	**Postcode**

24. What is the condition that you are claiming for (the medical diagnosis from a medical practitioner)

25. If claiming for a physical injury or disease, which parts of your body are affected?

26. What tasks were you doing when you were injured?

27. Describe what happened and how you were injured

28. If there was a witness to the injury occurring, provide their contact details:

Name
Phone
Email
Relationship to you

29. When did you first notice your symptoms or injury?

Date	**Time**

30. How long do you expect to be absent from work due to your injury or illness?

☐ No absence ☐ Less than 12 weeks
☐ Less than 1 week ☐ Longer than 3 months

31. If you stopped work, what was the date and time?

Date	**Time**

☐ N/A

32. If you resumed work, what was the date and time?

Date	**Time**

☐ N/A

33. At the time you were injured or became ill, were you taking any prescribed medication or under the influence of alcohol or other drugs?

☐ Yes ☐ No – go to the next question

If yes, please provide details:

If you believe that there are additional circumstances relevant to your situation, please attach a separate signed and dated statement. Further information and a statement template are available on the ACTPS Employment Portal.

If you are claiming for a psychological injury you must attach a statement outlining the events that contributed to your injury in support of your claim.

34. Was your injury as a result of driving, or using a motor vehicle, or the use of public transport?

☐ Yes ☐ No – go to the next question

If yes, you need to also complete the *Journey claim form and attach it to this claim form.*

Journey claim forms are available on the ACTPS Employee Portal

35. Do you intend to make a claim (other than this claim), or take any other action, against any other third party for this injury (Eg. motor accident insurance, secondary or previous employer) in relation to this or any other injury?

☐ Yes ☐ No ☐ Unsure

You must inform the Claims Manager in writing when initiating a claim against the ACT government or a third party in respect of your injury/illness. Failure to notify within seven days of initiating proceedings may result in a penalty.

36. Have you completed a WHS incident report for this injury or illness with your employer?

☐ Yes ☐ No

37. Were you employed anywhere else at the time of your injury or illness(including self-employment, voluntary or unpaid work)?

☐ Yes ☐ No – go to the next question

If yes, please provide details:

Job Title
Employer/Company

38. When did you first seek or attend medical treatment?

Date

39. Name of your general practitioner(s)

40. Location of your medical practitioner

Practic name	
Address	
State	**Postcode**
Phone	

41. Other treatment providers (Eg. surgeon, physiotherapist, chiropractor, psychologist)

42. Have you been referred for medical investigations (eg. an MRI, ultrasound, CT, Xray or other tests)

If yes, please provide details:

If yes, attach a copy of the referral/s to this claim form.

43. Have you ever experienced a similar symptom to this injury or illness, whether it was work-related or otherwise?

☐ Yes ☐ No

44. Have you ever claimed compensation through any insurance for a similar injury or condition to this the claim you are making now?

☐ Yes ☐ No – go to the next question

Examples of other claims for compensation can include, but are not limited to:

- *Department of Veterans' Affairs*
- *the Dust Diseases Tribunal*
- *motor vehicle accident*
- *any workers' compensation scheme.*

If yes, please provide details:

Diagnosis
Bodily location
Date of injury
Reference no.
Insurer name

45. Any other information that you consider relevant for the purposes of your claim and medical treatment?

Your banking details

Any medical expense payments that are due to you will be paid by electronic funds transfer (EFT) into your bank account. Please provide your bank details and sign the authorisation.

Name of Institution

Branch

Address

State

Postcode

Account name

BSB number

Account number

Authorisation: I authorise the delegated claims administrator to make payments into my nominated bank account.

Print your name

Signature

Date

Checklist

Use this checklist to ensure you have supplied everything required. Please ensure you have provided all the attachments and authorisations, as failure to do so may delay a decision on your claim.

Signatures/authorisations

- [ ] Have you signed the Employee's authority and declaration section on page 3?
- [ ] Have you completed and signed the bank details on this page?

Attachments

- [ ] Have you attached a Certificate of Capacity? This needs to be completed by a legally qualified medical practitioner such as your GP or medical specialist and includes the diagnosis and causation of your condition.

  Or

- [ ] If you are claiming for chiropractic, physiotherapy, dentistry or osteopathic treatment only and not for time off work, have you attached a certificate from the practitioner who is performing this treatment?
- [ ] Have you written and attached an additional list of medical practitioners related to your claim, not already included on this form?
- [ ] If applicable, have you completed and attached the Journey form for injuries that occurred whilst travelling for work purposes?
- [ ] For psychological injury claims, have you included a statement outlining the events that occurred in support of your claim?
- [ ] Have you attached any other information you think is relevant to determining this claim? Please note that any statements must be signed and dated.
- [ ] Have you attached an additional list for any other similar injury or condition that you have claimed for in the past?

Next steps

Keep a copy of your claim form and a record of the date you gave the claim form and certificate of capacity to your employer. If you have not filled out this form with your employer, please give the completed form and all your attachments to your employer to finalise and lodge with the Work Safety Group. The claim form will then be provided to the delegated Claims Manager. Send your completed forms to injurymanagement@act.gov.au.

Employee details

1. First name(s)

2. Surname

3. AGS number

4. What is the employee's substantive level and local job title?

5. Position level at the time of the employee injury or illness (Eg. ASO4, SOG C)

6. How long have they been performing the role in which they were injured or became ill?

7. When did the employee commence employment with the ACTPS?

8. What were the employee's standard working hours at the time of the injury or illness (not including overtime)

9. Was the employee on higher duties at the time of the injury? If so, when does that cease?

   Date

10. Has the employee ceased employment with you? If so, what date did the employee cease employment?

    Date

11. What is the relevant Enterprise Agreement under which the employee is employed?

12. Is the employee permanent full time, permanent part time, temporary full time, temporary part time, casual or a contractor?

13. If contractor, what is the end of contract date?

    Date

Supervisor details

14. First name(s)

15. Surname

16. Position title

17. Contact Details

Phone
Mobile
Email

Person completing form

If you are not the employee's supervisor, please provide your contact details and relationship to the employee.

18. First name

19. Surname

20. Contact Details

Phone
Mobile
Email

21. Position title

22. Relationship to employee

How the injury occurred

23. Date of the incident, injury or illness

    Date

24. When were you notified about the injury or illness? Date notified (attach the WHS incident report with this form if completed)

    Date

25. When did you receive the claim form from the employee?

Date

26. Do you require a Pre-Liability Case Conference with the claims administrator?

☐ Yes ☐ No

A Pre-Liability Case Conference is your opportunity to provide additional facts for the Claims Manager to consider when determining this claim.

Return to Work Planning

Skip section if employee is completeing pre-injury duties and hours.

27. What was the date of the last contact with your employee?

Date

28. Have modified/alternate duties been offered?

☐ Yes ☐ No

If yes, please attach a description or plan.

If no, please detail why duties are not being offered.

Employer Acknowledgement

I acknowledge that I have received this form and completed the employer section.

Name
Position
Phone
Email
Signature
Date

Next steps

Send your completed forms to injurymanagement@act.gov.au.