ACT Workers Compensation
Early Injury Notification Form

Fax this form to your insurer within 48 hours of becoming aware of an injury. Retain this form in your Injury Register file.
Note that a normal claim form must still be completed and sent to your insurer within 7 days.

Employer Details

Employer name | ABN | Policy number

Business address

Suburb | State | Postcode | Country (if not Australia)

Postal address ☐ Tick if same as business address

Suburb | State | Postcode | Country (if not Australia)

Business hours phone | Fax | Email

Employer contact person(s) (must be authorised)

Injured Employees Details

Employees surname | Given name(s)

Home address

Suburb | State | Postcode | Country (if not Australia)

Business hours phone | Home phone | Mobile

Employees occupation | Industry

Male ☐ Female ☐ | Date of Birth

Injury Details

When did the injury happen?

Dat | Time | am ☐ pm ☐ | Tick if between these dates and times ☐ | Date | Time | am ☐ pm ☐

Exact address where the injury occurred

Suburb | State | Postcode | Country (if not Australia)

Injury Details Continued

Injury / disease suffered

Body part(s) affected by injury / disease

Cause of injury

Details of Nominated Doctor who is Treating the Injured Worker

Name of Medical Practice

Name of Doctor

Address of Medical Practice

Suburb

State

Postcode

Country (if not Australia)

Business hours phone

Fax

Email

First Aid Treatment

Was any first aid provided?

No ☐ Yes ☐ Please provide details, including names of providers and details of treatment provided

Witnesses

Were there any witnesses to the injury?

No ☐ Yes ☐

Name of witness

Position within Business

Address

Business hours phone

Fax

Mobile

Declaration and Privacy Consent

Your insurer has a detailed Privacy Policy in place - please contact them for a copy.

I declare that I have obtained the consent of the injured employee for the insurer and broker to disclose and obtain the injured employees personal information to and from other insurers, insurance reference services, credit reporting agencies, loss assessors & adjusters, investigators, medical practitioners, rehabilitation providers and legal advisers for the purpose of assessing my claim.

Signature of person registering the injury notification

Name

Date

Please ensure that a copy of this form is retained in your Injury Register file.