GIO WORKERS COMPENSATION

Example: WA Injury Management System

[Insert Company Name] Injury Management System Policy

[Insert Company Name] is committed to assisting employees who have sustained a work related injury or impairment to access the best possible medical treatment and to provide suitable duties to facilitate a return to gainful employment with the process beginning at the earliest possible moment.

Injury management co-ordinator

Your key contact for assistance with managing your workplace injury is:

[Insert Company's Name] Injury Management Co-ordinator's name. At [Insert Company Address]

On phone number [Insert Company Phone No.]

Injury management partners

To ensure you receive the best possible treatment and intervention to assist with your recovery [Insert Company Name] has formed alliances with the following injury management parties who know our company and our industry. These services will be engaged as required in consultation with yourself and our Injury Management Co-ordinator.

Preferred medical provider Contact details

Preferred vocational rehabilitation provider Contact person

Contact details

What you need to do as soon as an injury occurs:

- Report injury to your Supervisor.
- Obtain a First Medical Certificate from a Medical Practitioner of your choice.
- Complete a claim form and submit to [Insert Company's Name] Injury Management Co-ordinator within 3 working days of injury.
- Participate in your return to work program.

What [Insert Company Name] will do

- Arrange first aid.
- Arrange or escort you to your treating medical practitioner or Dr [Insert Doctor's Name].
- Provide you with an injury management kit, which includes the claim form.
- Work with you to identify suitable duties and develop a return to work program.
- In consultation with you, Name of [Insert Company's Name] Injury Management Co-ordinator will amend your return to work program in accordance with your treating medical practitioner's recommendations.

Example: WA Return to Work Program

Please print all details and provide signatures where required

Employee	Mr Joe Bloggs	Claim No	xxxx
Employee telephone No.	(xx) xxxx xxxx		
Position title	xxxx	Section	Warehouse/Dispatch
Supervisor	Mr Jack Jones	Telephone No.	(xx) xxxx xxxx
		Facsimile No.	(xx) xxxx xxxx
Insurer managing the claim	[Insert company name]		
Contact person	Jill Sims	Telephone No.	(xx) xxxx xxxx

Medical Details

Worker's treating medical practitioner	GP		
Email		Telephone No.	(xx) xxxx xxxx
Work restrictions on medical certificate	xxxx		
Date of review by worker's treating medical practitioner	xxxx		
Starting date	dd/mm/yy	Duration	4 weeks
Finish date	dd/mm/yy		

Goal

Mr Bloggs to return to 40 hrs/week as a Fork-lift/Dispatch Officer.

Date / time of commencement

Monday 15 August at 8.30am.

Review date

Thursday 25 August. Should any changes to the return to work program be made *[Insert Employer's Name]* will discuss them with the treating General Practitioner (GP) and Mr Bloggs prior to amending.

Example: WA Return to Work Program (continued)

Week	Duties	Mon	Tues	Wed	Thurs	Fri	Total
Week 1 dd/mm/yy	Co-ordinate incoming orders, check outgoing items, take telephone inquiries.	4 hrs 8am–12pm	–	4 hrs 8am–12pm	–	4 hrs 8am–12pm	12 hrs
Week 2 dd/mm/yy	As above plus, pack loads <5kg, fork-lift driving but not> 20 minutes at a time	6 hrs 8am–2pm inc.30min lunch break	–	6 hrs 8am–2pm inc.30min lunch break	*GP review	6 hrs 8am–2pm inc.30min lunch break	18 hrs
Week 3 dd/mm/yy	As above plus, packing and unpack loads <10kg, up to 1hr at a time fork-lift driving	8 hrs 8am–4pm inc.30min lunch break	4 hrs 8am–12 *Specialist review	8 hrs 8am–4pm inc.30min lunch break	4 hrs 8am–12	8 hrs 8am–4pm inc.30min lunch break	32 hrs
Week 4 dd/mm/yy	Full pre-injury duties	8 hrs 8am–4pm inc.30min lunch break	6 hrs 8am–2pm inc.30min lunch break	8 hrs 8am–4pm inc.30min lunch break	6 hrs 8am–2pm inc.30min lunch break	8 hrs 8am–4pm inc.30min lunch break	36 hrs

Recommendations

- Mr Bloggs to report any increase in symptoms immediately to Mr Jones and consult his treating General Practitioner as soon as a medical review can be arranged.
- To take regular stretch breaks.
- Mr Bloggs to continue physiotherapy on Tuesday and Thursday for Weeks 1 and 2.
- Dr GP to review Mr Bloggs and evaluate ongoing treatment on Thursday 25 August.
- If the program needs altering, all parties must be discussed and give approval.

Required actions	By Whom	By When
1. To attend Consultant Occupational Physician appointment on Tuesday 30 August at 2.30pm.	Mr Bloggs	dd/mm/yy
2. To report to Supervisor on each day of Program and advise of progress and concerns (if any).	Mr Bloggs	dd/mm/yy
3. To advise Injury Management Co-ordinator of Mr Blogg's progress, difficulties and concerns (if any).	Mr Bloggs	dd/mm/yy
4. To attend for medical review with treating medical practitioner on 25 August.	Mr Bloggs (& Mr Jones)	dd/mm/yy
5. To contact treating medical practitioner and Mr Bloggs to discuss, develop and obtain signed agreement for Return to Work Program 2.	Mr Bloggs	dd/mm/yy

I agree to the terms of this return to work program.

Employee's signature ______________________ Date / /

Print name Joe Bloggs

Co-ordinator's signature ______________________ Date / /

Print name Jack Jones – Supervisor

Example: WA Return to Work Program (continued)

Facsimile (9xxx xxxx)

To	(insert Dr Name)	From	(insert your Name)
Fax	(insert Dr Fax Number)	Date	

Dear Dr

We refer to the above-mentioned claim for which you are the treating medical practitioner.

(Company name) are committed to the rehabilitation of our employees. Every effort will be made by (company name) to assist in the management of injuries and an early return to appropriate duties and work hours.

From our experience, successful return to work is achieved when employees return to their pre-injury work site to be amongst their colleagues as soon as practicable after sustaining the impairment. We would therefore be grateful for your assistance in reviewing the attached proposed Return To Work Program.

We would welcome your recommendations if any changes are required or your signed consent to proceed.

Thank you for your assistance and we look forward to working with you to achieve a successful outcome for all parties.

Yours sincerely

Insert Name
Insert Position
Insert Company Name
Contact Number

Important Notice

Dispute Resolution

Employers / Insurers are required to comply with strict time frames for applications served out of the Conciliation & Arbitration Services (CAS).

Below is an example of application for conciliation. This can be made by an Injured Worker or by an Insurer on behalf of the Employer.

GOVERNMENT OF WESTERN AUSTRALIA | WorkCoverWA | Workers' Compensation Conciliation Service, 2 Bedbrook Place, Shenton Park WA 6008, Ph 08 9388 5555, @WorkCoverWA, www.workcover.wa.gov.au

APPLICATION FOR CONCILIATION
Form 100

Office use only

NOTES FOR APPLICANT

- Complete this form to apply to have your dispute dealt with by the Workers' Compensation Conciliation Service.
- You are required to have made attempts to resolve the dispute before lodging this form.
- You may apply for conciliation online at https://online.workcover.wa.gov.au/
- Attach a separate page(s) to this form if you do not have enough space.
- This form **must** be signed.
- Once you have completed your application we advise that you keep a copy for your records.
- Completed forms can be lodged by either:

POST	IN PERSON	EMAIL
Workers' Compensation Conciliation Service, WorkCover WA, 2 Bedbrook Place, SHENTON PARK WA 6008	WorkCover WA, 2 Bedbrook Place, SHENTON PARK WA 6008 (Monday to Friday, 8am to 5pm)	Documents may be lodged by email subject to conditions. See the WorkCover WA website.

For further information or assistance in completing this form, please contact WorkCover WA's Advice and Assistance Unit on 1300 794 744 or (08) 9388 5537 (TTY).

SECTION A - APPLICATION DETAILS

1. Applicant
(party who is making application, e.g. worker's name)

2. Respondent
(party who application is against, e.g. employer's name)

The Applicant is the *(tick relevant box)*
- ☐ Worker
- ☐ Employer
- ☐ Insurer
- ☐ Other *(please specify)*

The Respondent is the *(tick relevant box)*
- ☐ Worker
- ☐ Employer
- ☐ Insurer
- ☐ Other *(please specify)*

(Note: Form 105 to be completed if there are multiple respondents)

3. Lodged by *(tick relevant box)*
- ☐ Worker
- ☐ Employer
- ☐ Insurer
- ☐ Dependant
- ☐ Worker representative
- ☐ Employer representative
- ☐ Insurer representative
- ☐ Service provider
- ☐ Other *(please specify)*

4. All notices from the Workers' Compensation Conciliation Service are sent by mail. Indicate if the applicant's preference is to receive notices by email. ☐ Email

Form 100 WorkCover WA Page 1 of 4

If this application is sent to your organisation, please contact GIO immediately to discuss next steps.

Who we are

Insurance issued by AAI Limited ABN 48 005 297 807 trading as GIO.