GIO Workers Compensation – Australian Capital Territory

Initial Notification of Injury

This form may be used to notify GIO of a workplace injury or illness. Please notify GIO of any injury as soon as possible even if all of the information is not known.

Australian Capital Territory employers are legally required to notify GIO within 48 HOURS after becoming aware that a worker has sustained a workplace injury. The employer can notify GIO in the following ways:

- Phone: 02 6281 8806. If notification is provided by phone, the employer is legally required to also provide notice in writing within 3 days after the oral notification.
- Fax: 1300 725 840
- Email: wcclaimsact@gio.com.au

Note:

1. This is not a claim form. Completion and submission of claim forms are still required if a claim is lodged.
2. The employer is still required to maintain a Register of Injuries in the workplace.
3. If CCTV footage available, please save in the event that it is required.

The Workers Compensation Act 1951 (ACT), s.105 requires an Employer to provide suitable work for full-time, part-time and casual workers.

Purpose of notification

Notification only ☐ Treatment costs only ☐ Time lost from work ☐

Employer details

Policy number

Claim number (if applicable)

Name of employer (as appears on policy)

ABN

Cost centre (if applicable)

Address

Surburb State Postcode

Email address (employer representative)

Injured worker details

Name of injured worker

Title Surname Given name(s)

Date of birth / /

Gender Male ☐ Female ☐

Occupation

Employment type: Full time ☐ Part time ☐ Casual ☐

Residential address

Surburb State Postcode

Insurance is issued by AAI Limited ABN 48 005 297 807 trading as GIO.
18064 27/05/25 A

Home phone ( )

Mobile phone ( )

Email address

Notifier details

Date of notification to employer / /

Name of person making notification

Notifier's relationship to worker/employer (e.g. employer's representative, solicitor etc)

Workplace contact name (if different to notifier)

Telephone ( )

Fax ( )

Other information that may assist in the assessment of this claim (e.g. liability issues)

Has the injured worker been provided with the relevant claim forms? Yes ☐ No ☐

Injured worker remuneration details

Average weekly earnings ($wk) $

Average hours per week

Injury details

Date of injury / /

Time of injury (am/pm)

Address/location where injury occurred

Surburb State Postcode

Brief description of incident

Nature of injury (eg: laceration, anxiety attack)

Body part/s affected (eg: lower back, left ankle)

Has the injured worker suffered a previous similar injury?

If time lost, date ceased work / /

Time ceased work

Date of return to work (if applicable) / /

Current work fitness: Unfit ☐ Pre-injury duties ☐ Suitable duties ☐

Has the injured worker provided a medical certificate for this injury? Yes ☐ No ☐

Treatment details

Has the injured worker received medical treatment? Yes ☐ No ☐

Doctor/hospital name (include address if known)

Telephone ( )

Fax ( )

Notifier's signature

Date / /

When completed, please return this form to:

Email: wcclaimsact@gio.com.au Fax: 1300 725 840