

GIO WORKERS COMPENSATION AUSTRALIAN CAPITAL TERRITORY

STATEMENT OF WITNESS TO AN INJURY

Please print all details and provide signatures where required

Injured person

Employed by

Workers Compensation claim number (if known) (Please quote on all communications)

Details of witness making this statement

Title Surname

Given name(s)

Residential address

Suburb

State

Postcode

Phone number: Home

Work

Current employer

Work Address

Suburb

State

Postcode

Name of your foreman or supervisor

Accident details

Did you actually see the accident?

Yes No

Were there any other persons present at the time?

Yes No

If other persons present what were their names?

How did injured person say the accident occurred?

When did it happen?

Day of the week

Date

Time



Where did it happen? Address and location

How did it happen? (Full description of events leading to accident and actually occurring at time of accident)

What was injured person doing at time of accident?

What did you notice about the injured person? (Such as bleeding, vomiting, limping, etc.)

What complaints did the injured person make (such as where was the pain?)

Did the injured person continue to work? (If yes, for how long and in what manner?)

Declaration

By signing this application, I agree to GIO collecting, using and disclosing my personal information, including sensitive and health information if applicable, in accordance with the GIO Privacy Statement available at gio.com.au and the Group Privacy Policy.

I (Print name) declare the truth of the above statement.

Date / / Signature

Declaration

This declaration to be completed where witness does not understand written English

(a) I have had the questions on this form and my answers to those questions, together with this declaration read and explained to me in

my native language which is:

by (name of interpreter)

and I confirm that my answers as interpreted to me are correct and that I understand the meaning of the declaration made by me,

Signature of witness

(b) Declaration of interpreter

I

(name, address and occupation) certify that I translated the questions on this form and the declarations on this form to:

(witness's name) from the English language into

language and the

language into the

English language to the best of my skill and ability.

I am satisfied that (witness name)

understood the questions on the form and the declarations on the form.

I certify that the answers as translated by me are correct translations of the witness answers to those questions.

Signature of interpreter

I declare that the foregoing is correct

Signature of witness

I declare that the person making this statement is known to me and signed in my presence.

Declared at on the (day)

day of (month) 20 (year)

before me (Justice of Peace)

(print name)

KNOW NOW

How to return this form

- Email: wclaimsact@gio.com.au
- Post: ACT Claims, PO Box 47, Woden, ACT, 2606

How to contact us

- Phone: **13 10 10**
- Fax: **1300 725 840**
- Web: **gio.com.au**



Who we are

This insurance is issued by AAI Limited
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