

Notification of Injury/Illness

Incident only:

Treatment only:

Time lost from work?

To lodge a new claim:

Email to sydneyimc@gio.com.au or fax documents to **1300 733 677**

Injured worker details

First Name

Surname

Claim no.

Date of birth

/ /

Occupation

Gender

Address

Suburb

State

Postcode

Home phone no.

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Mobile no.

Email address

Workers Declaration

I have not received any medical treatment following this incident nor see a need to seek medical treatment. I have lost no time from work.

Signature

Date

/ /

Injury details

Date of injury

/ /

Date ceased work

/ /

Has employee returned to pre-injury duties?

Yes

No

Date

/ /

Returned on suitable duties (full hrs)?

Yes

No

Date

/ /

Returned on suitable duties (reduced hrs)?

Yes

No

Date

/ /

Is employee still unfit for work?

Yes

No

Anticipated return date:

/ /

Nature of injury/illness:

Describe how the injury/illness happened:

Address where injury/illness occurred:

Suburb

State

Postcode



Treatment details

Doctor's Name

or Hospital

Address

Suburb

State

Postcode

Phone no.

Fax no.

PIAWE details (pre-injury average weekly earnings) – if notification only details not required

Date employed

Employment type:

Full time

Part time

Casual

Other

Wage information

Ordinary hours worked per week:

Ordinary gross earnings per week:

Ordinary gross hourly rate

Are any of the following paid on top of the ordinary gross earnings?
Please provide value of the payments for the 52 weeks prior to the date of injury.

Overtime

Shift allowance

Commission

Piece rates

Has there been any change in working hours/rates in the 52 weeks prior to the injury? (This could include promotion, reduction in working hours etc.)

Yes

No

Brief description of change and date:

Leave

In the 52 weeks prior to the date of injury was any leave taken?

Yes

No

Paid annual leave (weeks)

Paid other leave (weeks)

Unpaid leave (weeks)

Non-pecuniary benefits:

Were any of the following non-pecuniary benefits received as part of pay? Please state the monetary value of the non-pecuniary benefits, including the Fringe Benefits Tax value, in the 52 weeks prior to the date of injury.

	Monetary value of non-pecuniary benefits (\$)	Date
Use of motor vehicle \$:	\$	/ /
Residential Accommodation \$:	\$	/ /
Health Insurance \$:	\$	/ /
Education Fees \$:	\$	/ /

Wage information

Will the worker be retaining use of any of these non-pecuniary benefits while they are unable to work?

Yes

No

If yes, please list each item:

Employer comments

Policy no.

Business name (as per policy)

Address

Suburb

State

Postcode

Phone no.

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Employer fax no.

Employer contact

Contact phone no.

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Date employee notified employer of injury/illness:

/ /

Cost Centre

Cost Centre 2

Notifier's relationship to Worker/Employer:

Name of person making notification:

Phone number of person completing form:

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Address of notifier

Suburb

State

Postcode

Employer Signature

Date

/ /

Please print name