This report can be used to lodge a Workers' Compensation Claim in New South Wales, Queensland, or Victoria

WorkCover NEW SOUTH WALES | WorkCover QUEENSLAND | WorkSafe VICTORIA

EMPLOYER INJURY CLAIM REPORT

Please indicate in which State you want to lodge this claim:

[ ] New South Wales [ ] Queensland [X] Victoria

1 EMPLOYER'S DETAILS

Legal name
Victoria State Emergency Service

Trading name
Victoria State Emergency Service

Employer's scheme registration number
eg. WorkSafe Employer, Policy, or Employer Registration Number
11845623

Employer's reference number *(Your reference)*

* *This question is required for NSW claims*

*** Policy period of insurance**
/ / to / /

Street address
168 Sturt Street

Suburb
Southbank

State Victoria **Postcode** 3006

Postal address
168 Sturt Street
Southbank Vic 3006

Australian Business Number
61279597238

ACN/ARBN

Division **Cost Centre**

What is the main business activity at the incident site?
Emergency Service

Name, position, and daytime contact number of employer contact
Natasha Gorgiev
(03) 9256 9060

Name and daytime contact number of the return to work coordinator (if any)
Rachel Treeby
(03) 9256 9059

Address for correspondence relating to this claim
Postal address
168 Sturt Street, Southbank

State Victoria **Postcode** 3006

Employer contact e-mail address
rachel.treeby@ses.vic.gov.au

If you need an interpreter, what language do you speak?

When did you receive the worker's completed claim form?
02 / 11 / 17

When did you receive the worker's first medical certificate?
02 / 11 / 17

2 WORKER'S DETAILS

Family name
Laidlaw

Given names
Geoffrey Maxwell

Street address
12 Chandler Drive

Suburb South Morang **Postcode** 3752

Daytime contact phone number/s
M 0409140248 W 92569226 H 94041028

Date of birth 21 / 04 / 49 **Gender** [X] Male [ ] Female

3 WORKER'S EMPLOYMENT DETAILS

Street address of the worker's usual workplace
239 Proximity Drive

Suburb
Sunshine West

State Victoria **Postcode** 3020

This question is required for NSW claims

How many workers are employed at this workplace?

This question is required for Victorian claims

Workplace number for worker's usual workplace
30857731

If the incident did NOT happen at one of your workplaces, please give the name of the employer responsible for the workplace

Employer's name

What is the worker's usual occupation?

What are the main tasks performed by the worker in their usual occupation?

Which of the following apply to the worker?
(Please tick all relevant boxes)

[ ] Casual [ ] Student
[X] Full-Time [ ] Part-Time [ ] Apprentice [ ] Volunteer
[ ] Contract [ ] Trainee [ ] Agency worker [ ] Contractor
[ ] Permanent [ ] Temporary [ ] Seasonal [ ] Jockey

Other?

When did this worker start working for you?
07 / 12 / 10

* *These questions are required for NSW and QLD claims*

Is the worker employed under any of the following?

[ ] Federal award [ ] Registered industrial agreement
[ ] State award [ ] No agreement or award
[ ] WCA Jobcover Program [ ] Registered enterprise agreement

*** What is the title of the award or agreement?**

What is the worker's minimum weekly wage?
As specified by the award or agreement $

4 WORKER'S RETURN TO WORK DETAILS

If the worker has returned to work, please provide the date
/ /

What duties are they doing? [ ] Full [ ] Suitable/Modified

How many hours do they work each week? hrs

How many days have been lost? days hrs

Have you provided the worker with a return to work plan, taking into account the injury/condition?
Please attach a copy of the return to work plan or agreement, or please explain why you have not provided a plan.

If the worker has not returned to work, do you know of any issues that would delay or prevent a return to work?

5 CLAIM CONFIRMATION DETAILS

Do you agree that the details provided in sections 2 & 4 of the *Worker's Injury Claim Form* are correct? [X] Yes [ ] No

Do you accept that your worker has an injury/condition which is work-related and occurred while in your employment? [X] Yes [ ] No

Note: If you agree the injury is work-related, and believe that the details provided in sections 2 & 4 of the Worker's Injury Claim Form are correct, you do not need to complete the remainder of this form except for section 9, which MUST be completed. Otherwise, please complete any relevant questions in sections 6, 7 and 8 of this Report.

6 WORKER'S EARNING DETAILS

Please complete this section if you wish to claim for weekly payments

How many standard hours did the worker work each week before being injured? *Exclude overtime* hrs

What were the worker's usual working hours?
For example, Monday to Friday, 8.30 am to 5.30 pm

What was the worker's usual gross hourly rate? *Exclude overtime & shift allowances* $

What was the worker's usual gross weekly earnings? *Exclude overtime & shift allowances* $

Please provide details of any overtime or shift work

Average weekly overtime hrs $

Weekly shift allowance $

Please provide payroll records covering the 12 months prior to injury

7 INCIDENT DETAILS

What is the worker's injury/condition, and which parts of the body are affected?
Rupture of achilles tendon

What happened and how was the worker injured?
Stepped off kerb onto road and left ankle popped and gave way

What is the street address where the incident occurred?
270 Darebin Road

Suburb
Fairfield

State
Victoria

What date and time did the injury occur?
31 / 10 / 17 2.15pm AM PM

What date and time did the worker first cease work?
31 / 10 / 17 4.00pm AM PM

Which of the following incident circumstances apply?

- [ ] *While working at the usual workplace*
- [X] *While working away from the usual workplace*
- [ ] *During a meal-break or authorised recess at work*
- [ ] *While away from work during a recess*
- [ ] *Travelling to or from work**
- [ ] *A motor vehicle accident while working**

** For NSW incidents a journey claim form must also be completed*

If the injury was the result of driving or using a motor vehicle or the use of public transport, please provide the registration number/s of any vehicles involved

State

Has the worker had a similar injury/condition or personal injury claim before that relates to this injury/condition?
Please give details, including claim numbers

When did the worker report the injury to you?
31 / 10 / 17

Who was the injury reported to?
Chris Myers

What are the names and daytime contact details of any witnesses?
Rebecca Kovak (03) 8480 9700
Stewart Heaton

Do you believe that the injury/condition was caused or contributed to by the worker, or a third party such as a manufacturer or supplier? *Please give details if relevant*

8 ADDITIONAL INFORMATION

Do you want to provide any additional information that may assist in the determination of liability or the management of this claim? *eg. Do you dispute liability, and, if so, why?*

9 EMPLOYER'S DECLARATION

I have read the information provided in this form. I declare that the information I have supplied in this form, and any attachment to this form, is true and correct and that no information has been suppressed or omitted from this report to the best of my knowledge. I understand that the making of a false or misleading statement concerning a claim is punishable by law and that I may be prosecuted.

Signature of employer's representative **Date**
02 / 11 / 17

Name
Natasha Gorgiev

Position
WHS Administrator

ORIGINAL