## David Berlusconi

**From:** David Berlusconi
**Sent:** Friday, 11 January 2019 1:15 PM
**To:** mail@eml.com.au
**Subject:** CLAIM # 1869650
**Attachments:** Untitled_20190110_144942.pdf

Regards.

David Berlusconi
Human Resources Manager
Australian Automotive Group Pty Limited
60 O'Riordan Street, Alexandria
NSW, 2015, Australia
P | +61 2 9332 8167 F | +61 2 9360 5375
M| +61 417 293 398 E | dberlusconi@aag.com.au

## David Berlusconi

**From:** David Berlusconi
**Sent:** Friday, 11 January 2019 12:53 PM
**To:** Paul Gerethy
**Cc:** Chris Williams
**Subject:** FW: w/comp forms Jesus Oretga
**Attachments:** Untitled_20190110_144942.pdf

Hi Paul,

Can you please send me an injury form for this. They are located on the intranet
http://intranet.austautogroup.com.au/wp-content/uploads/62.-Incident-Report-Form-13.11.17.pdf

Regards.

David Berlusconi
Human Resources Manager
Australian Automotive Group Pty Limited
60 O'Riordan Street, Alexandria
NSW, 2015, Australia
P | +61 2 9332 8167 F | +61 2 9360 5375
M| +61 417 293 398 E | dberlusconi@aag.com.au

-----Original Message-----
From: Lena Muscat On Behalf Of Payroll - AAG
Sent: Thursday, 10 January 2019 3:57 PM
To: David Berlusconi
Subject: FW: w/comp forms Jesus Oretga

Do you know anything about this?

Lena Muscat

Payroll Manager
Australian Automotive Group
60 O'Riordan St. Alexandria NSW 2015
Ph: 02 9332 8183 M: 0418 220 947
lmuscat@austautogroup.com.au

-----Original Message-----
From: Caroline Frater
Sent: Thursday, 10 January 2019 3:53 PM
To: Payroll - AAG
Subject: w/comp forms Jesus Oretga

Not sure if u have been sent these

NSW GOVERNMENT | WorkCover

# WorkCover NSW – certificate of capacity

**Please ensure all sections are completed. Tick if this is the initial certificate for this claim** ☑

PART A – MAY BE COMPLETED BY PATIENT

Patient's first name: JESUS

Last name: ORTEGA LOVERA

Date of birth (DD/MM/YYYY): 25/11/1982

Telephone number: 0404201377

Patient's address: 13/115 Lagoon Street, NARRABEEN, NSW, 2101, 0404201377

Claim number:

Medicare number:

**Shaded areas to be completed for initial certificate only**

Patient's occupation/job title: mechanic

Employer's name and contact details: Titan Ford, 780 PITTWATER RD, BROOKVALE, NSW, 2100

**I consent to my treating medical practitioner, my employer, the insurer, other treating practitioners, workplace rehabilitation providers and WorkCover exchanging information for the purposes of managing my injury and workers compensation claim. I understand that this information will be used by WorkCover and insurers to fulfil their functions under the workers compensation legislation.**

Signature of patient: Jesus. O

Date (DD/MM/YYYY): 08/01/2019

PART B – TO BE COMPLETED BY NOMINATED TREATING DOCTOR OR TREATING SPECIALIST MEDICAL PRACTITIONER

## MEDICAL CERTIFICATION

Diagnosis of work related injury/disease: LAceration to right middle finger

Patient stated date of injury: 08/01/2019

**Shaded areas to be completed for initial certificate only**

Patient was first seen at this practice/hospital for this injury/disease on: 08/01/2019

Injury/disease is consistent with patient's description of cause: ☑ Yes ☐ No ☐ Uncertain

How is the injury/disease related to work?: hit finger on engine

Detail any pre-existing factors which may be relevant to this condition: nil

WORK SAFE HOME SAFE

Claimant name | Claim number

## MANAGEMENT PLAN FOR THIS PERIOD

Treatment/medication type and duration (Duration: short term = < 6 weeks, medium term = 6–12 weeks, long term = > 12 weeks)

WOund cleaned and sutured adt given

Referral to another health care provider (provide details of provider and service requested, duration and frequency when relevant)

## CAPACITY FOR EMPLOYMENT (Please consider the health benefits of work when completing this section)

Do you require a copy of the position description/work duties? ☑ Yes ☐ No

Patient

☐ is fit for pre-injury duties

☑ has capacity for some type of employment from 09/01/2019 | to 16/01/2019

for 8 | hours / day 5 | days / week

☐ has no current work capacity for any employment from / / to / /

If no current work capacity, estimated time to return to any type of employment

Factors delaying recovery

Do you recommend referral to workplace rehabilitation provider? ☐ Yes ☑ No

**Capacity -** If the patient is fit for pre-injury duties this section does not need to be completed. For all other patients please consider activities of daily living currently being performed.

Lifting/carrying capacity

Sitting tolerance

Standing tolerance

Pushing/pulling ability

Bending/twisting/squatting ability

Driving ability

Other (please specify) eg psychological considerations, keep wound clean and dry

keep finger clean covered and dry

Next review date / / (if greater than 28 days, please provide clinical reasoning)

Comments

## TREATING MEDICAL PRACTITIONER DETAILS

☐ Please tick if you agree to be the nominated treating doctor for the ongoing management of this worker's injury and return to work.

**I certify that I am the ☑ nominated treating doctor or ☐ treating specialist or ☐ other* and I have examined this patient.**
**The information and medical opinions contained in this certificate are, to the best of my knowledge, true and correct.**

Signature

Date (DD/MM/YYYY)
08/01/2019

*If 'other', please specify

(practice stamp if available)

Name
Dr Jennifer Wines

Address
10 Dale Street, BROOKVALE, NSW, 2100

Telephone number
02 9938 6666

Fax number
02 9905 4290

Provider number
027267FH

PART C – TO BE COMPLETED BY THE WORKER PRIOR TO SENDING TO THE EMPLOYER OR INSURER
(this does not involve the nominated treating doctor/treating specialist)

## WORKER DECLARATION

Worker's first name
JESUS

Last name
ORTEGA LOVERA

Date of birth (DD/MM/YYYY)
25/11/1982

Worker's address
13/115 Lagoon Street, NARRABEEN, NSW, 2101, 0404201377

Claim number

I [ ] have [ ] have not (tick appropriate box)
**engaged in any form of paid employment, self employment or voluntary work for which I have received or am entitled to receive payment in money or otherwise since the last certificate was provided, that I have not yet declared to the insurer.**

If you have been engaged in any form of paid employment or voluntary work, please provide details below (or attach when you forward this certificate to your employer or insurer).

**I declare that the details I have given on this declaration are true and correct, knowing that false declarations are punishable by law.**

Signature of worker

Jesus O

Date (DD/MM/YYYY)
08/01/2019

Catalogue No. WC01300 WorkCover Publications Hotline 1300 799 003
WorkCover NSW, 92-100 Donnison Street, Gosford, NSW 2250
Locked Bag 2906, Lisarow, NSW 2252 | WorkCover Assistance Service 13 10 50
Website workcover.nsw.gov.au

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NSW GOVERNMENT | WorkCover

# WorkCover NSW – certificate of capacity

**Please ensure all sections are completed. Tick if this is the initial certificate for this claim** ☑

PART A – MAY BE COMPLETED BY PATIENT

Patient's first name: JESUS

Last name: ORTEGA LOVERA

Date of birth (DD/MM/YYYY): 25/11/1982

Telephone number: 0404201377

Patient's address: 13/115 Lagoon Street, NARRABEEN, NSW, 2101, 0404201377

Claim number:

Medicare number:

**Shaded areas to be completed for initial certificate only**

Patient's occupation/job title: mechanic

Employer's name and contact details: Titan Ford, 780 PITTWATER RD, BROOKVALE, NSW, 2100

**I consent to my treating medical practitioner, my employer, the insurer, other treating practitioners, workplace rehabilitation providers and WorkCover exchanging information for the purposes of managing my injury and workers compensation claim. I understand that this information will be used by WorkCover and insurers to fulfil their functions under the workers compensation legislation.**

Signature of patient: Jesus. O.

Date (DD/MM/YYYY): 08/01/2019

PART B – TO BE COMPLETED BY NOMINATED TREATING DOCTOR OR TREATING SPECIALIST MEDICAL PRACTITIONER

## MEDICAL CERTIFICATION

Diagnosis of work related injury/disease: Laceration to right middle finger

Patient stated date of injury: 08/01/2019

**Shaded areas to be completed for initial certificate only**

Patient was first seen at this practice/hospital for this injury/disease on: 08/01/2019

Injury/disease is consistent with patient's description of cause: ☑ Yes ☐ No ☐ Uncertain

How is the injury/disease related to work?: Hit finger on engine

Detail any pre-existing factors which may be relevant to this condition: nil

WORK SAFE HOME SAFE

Claimant name | Claim number

## MANAGEMENT PLAN FOR THIS PERIOD

Treatment/medication type and duration (Duration: short term = < 6 weeks, medium term = 6–12 weeks, long term = > 12 weeks)

Wound cleaned and suturedwith2x3/0 nylon ADT given For ROS 7 days Keep wound cleanand dry

Referral to another health care provider (provide details of provider and service requested, duration and frequency when relevant)

Nil

## CAPACITY FOR EMPLOYMENT (Please consider the health benefits of work when completing this section)

Do you require a copy of the position description/work duties? ☑ Yes ☐ No

Patient

☐ is fit for pre-injury duties

☐ has capacity for some type of employment from / / to / /

for 0 hours / day 0 days / week

☑ has no current work capacity for any employment from 08/01/2019 to 08/01/2019

If no current work capacity, estimated time to return to any type of employment

Factors delaying recovery

Do you recommend referral to workplace rehabilitation provider? ☐ Yes ☐ No

**Capacity -** If the patient is fit for pre-injury duties this section does not need to be completed. For all other patients please consider activities of daily living currently being performed.

Lifting/carrying capacity

Sitting tolerance

Standing tolerance

Pushing/pulling ability

Bending/twisting/squatting ability

Driving ability

Other (please specify) eg psychological considerations, keep wound clean and dry

Next review date / / (if greater than 28 days, please provide clinical reasoning)

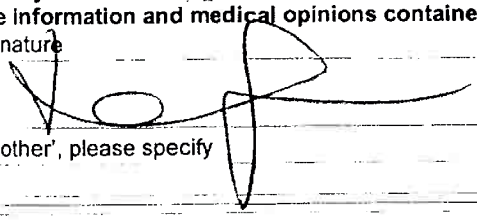
Comments

## TREATING MEDICAL PRACTITIONER DETAILS

☐ Please tick if you agree to be the nominated treating doctor for the ongoing management of this worker's injury and return to work.

**I certify that I am the ☐ nominated treating doctor or ☐ treating specialist or ☐ other* and I have examined this patient. The information and medical opinions contained in this certificate are, to the best of my knowledge, true and correct.**

Signature



Date (DD/MM/YYYY) 08/01/2019

*If 'other', please specify

Name (practice stamp if available)

Dr Jennifer Wines

Address

10 Dale Street, BROOKVALE, NSW, 2100

Telephone number 02 9938 6666

Fax number 02 9905 4290

Provider number 027267FH

PART C – TO BE COMPLETED BY THE WORKER PRIOR TO SENDING TO THE EMPLOYER OR INSURER
(this does not involve the nominated treating doctor/treating specialist)

## WORKER DECLARATION

Worker's first name
JESUS

Last name
ORTEGA LOVERA

Date of birth (DD/MM/YYYY)
25/11/1982

Worker's address
13/115 Lagoon Street, NARRABEEN, NSW, 2101, 0404201377

Claim number

I ☐ have ☑ have not (tick appropriate box)
**engaged in any form of paid employment, self employment or voluntary work for which I have received or am entitled to receive payment in money or otherwise since the last certificate was provided, that I have not yet declared to the insurer.**

If you have been engaged in any form of paid employment or voluntary work, please provide details below (or attach when you forward this certificate to your employer or insurer).

**I declare that the details I have given on this declaration are true and correct, knowing that false declarations are punishable by law.**

Signature of worker
JESUS .O

Date (DD/MM/YYYY)
08/01/2019

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icare
workers
insurance

# certificate of currency nsw

**issue date**
04/08/2018

**print date**
04/08/2018

LENA MUSCAT
AUSTRALIAN AUTOMOTIVE GROUP PTY LIMITED
811 ELIZABETH ST
ZETLAND NSW 2017

Dear LENA

## statement of coverage

The following policy of insurance covers the full amount of the employer's liability under the *Workers Compensation Act 1987(NSW).*

## valid until

01/09/2019

| policy number | legal name |
|---|---|
| 117289201 | AUSTRALIAN AUTOMOTIVE GROUP PTY LIMITED |

| trading name | abn | acn |
|---|---|---|
| | 84 088 817 912 | 088 817 912 |

| industry classification number (WIC) | number of workers* | wages/units+ |
|---|---|---|
| 531100 Car Retailing | 390 | $42,606,349.11 |

* Number of workers includes contractors/deemed workers
+ Total wages/units estimated for the current period

# important information

Principals relying on this certificate should ensure it is accompanied by a statement under section 175B of the *Workers Compensation Act 1987 (NSW).* Principals should also check and satisfy themselves that the information is correct and ensure that the proper workers compensation insurance is in place, ie. compare the number of employees on site to the average number of employees estimated; ensure that the wages are reasonable to cover the labour component of the work being performed; and confirm that the description of the industry/industries noted is appropriate. A principal contractor may become liable for any outstanding premium of the sub-contractor if the principal has failed to obtain a statement or has accepted a statement where there was reason to believe it was false.

Yours faithfully,

Jason McLaughlin
General Manager, Loss Prevention and Pricing
icare workers insurance