VICTORIA State Government | WorkSafe VICTORIA

This form can be used to lodge a workers' compensation claim in Victoria

Complete this form using a dark blue or black pen. Alternatively, you can download the form as a PDF, complete, print and sign. Visit **worksafe.vic.gov.au/resources/workers-injury-claim-form**

Worker's Injury Claim Form Part A

As the worker, you need to complete questions 1 to 6 on Part A of this form.

As the employer, you need to complete:

- Part A question 7, and
- Part B question 8.

1. Worker's personal details

Title: Mr	Family name: Gutierrez Niot
Given names: Andres Fabian	

Other known or previous legal names e.g. Maiden name

Date of birth: 07/07/1996

Gender: Male [X] Female [ ]

Residential street address

255 Sun crescent sunshine 3020

Suburb: Sunshine | State: Vic | Postcode: 3020

Postal address for correspondence

As above

What are your daytime contact phone numbers?

Mobile: 0473208394 | Work: | Home:

Email address

andresgutini77@gmail.com

Please read the information on "Communicating with you" on page 7 and indicate below if you agree to WorkSafe sending you personal and health information relating to your claim via email and SMS.

I agree [X] I do not agree [ ] (WorkSafe will communicate with you via post)

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

Spanish

Do you have special communication needs because of disability? e.g. Hearing or vision impairment

No

2. Incident & worker's injury details

Is your injury: A physical injury [X] A mental injury [ ]

You can tick **one or both** options above.

What is your injury/condition, and which parts of your body are affected?

Right hand and left hand injury

What happened and how were you injured?

It has developed gradually but I have not been able to work since 18/03/2025

What task/s were you doing when you were injured?

It has occured while using the plastic cutting machine

What area of the worksite were you working in when you were injured?

In the plastic machine area

What is the street address where the incident occurred?

119/121 William English Dr Laverton North 3026

Name of employer responsible for this workplace

Pact Reuse

Which of the following incident circumstances apply?

- [✓] While working at your usual workplace
- [ ] While working away from your 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 you were working

If your injury was the result of driving or using a motor vehicle or the use of public transport, please provide the following details:

The police station the accident was reported to

N/A

Registration number/s of involved vehicles | State

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

NO

What was the date and time the injury/condition occurred?

Date 18/03/2025 Time 8 am

When did you first notice the injury/condition?

It developed gradually

If you stopped work, what was the date and time?

Date 18/03/2025 Time 8 am

When did you report the injury/condition to your employer?

I reported it on 17/03/2025

What is the name and position of the person you reported the injury/condition to?

Yavet

If you did not report the injury/condition, or there was a delay, please explain why

What are the names and daytime contact details of anyone who witnessed the incident?

Wildor Flores has seen me having difficulties in doing my duties after cutting ~~plaster~~

Have you previously had another injury/condition or personal injury claim that relates to this injury/condition?
Please give details, including claim numbers

NO

3. Worker's employment details

Name of organisation paying your wages when you were injured

Symmetry

Street address of your usual workplace

119/121 William Anglish Dr

Suburb	State	Postcode
Lavar Lo n North	VIC	3026

Name and daytime phone number of employer contact
e.g. Name of Return to Work Coordinator

+61 470 186 326

What is your usual occupation? What do you do?

Labour

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

Full-time	✓	Part-time		Casual	✓	Student	
Apprentice		Volunteer		Contract		Trainee	
Agency worker		Contractor		Permanent		Temporary	
Seasonal		Jockey					

Other

When did you start working for this employer?

Oct 17, 2024.

Please indicate if any of the following apply to you:

A director of my employer's company	Yes		No	
A partner in my employer's company	Yes		No	
A sole trader	Yes		No	
A relative of my employer	Yes		No	

Did you have any other employment at the time you were injured?
Please provide or attach the names of any other employers and their contact details, and any relevant wage or payment records

NO

4. Worker's primary earning details

Please complete these questions if you wish to claim for weekly payments

How many standard hours did you work each week before being injured? Exclude overtime

37.5

What were your usual working hours?
For example, Monday to Friday, 8:30 am to 5:30 pm

From 4 pm to 12 am

What was your usual pre-tax hourly rate?*
Exclude overtime & shift allowances

$35.91 Per week

What were your usual pre-tax weekly earnings?*
Exclude overtime & shift allowances
* Please provide copies of any recent payslips (if available)

$1,346.63 Per week.

Please provide details of any overtime or shift work

Weekly shift allowance:

Weekly overtime (hours):

5. Treatment & return to work details

Please provide the name, clinic or hospital, and contact details of any medical providers (including clinics or hospitals) that have treated your injury

Dr Cesar Tan
Sunshine city Medical centre.

If you have returned to work with your employer, what was the date?

Not yet

What duties are you doing? Full ☐ Suitable/Modified ☐

How many hours are you working each week?

None

Have you returned to work with a new employer?
Please provide the name and contact details of the new employer

NO

If you have not returned to work, do you think that there are any issues that would delay or prevent you from returning to work?

When did/will you give your employer this claim form?

Today 25/03/2025

How did/will you give this claim form to your employer?

Hand delivery ☐ By post ☑ Email

When did/will you give your employer the first medical certificate?

Today 28/03/2025

6. Authority to release medical information and worker's declaration

I have read the information provided in this form. **I declare** that the information that I have supplied in this form, and any attachments to this form, is true and correct to the best of my knowledge. **I understand** that the making of a false or misleading claim or false and misleading statement in support of the claim is punishable by law and that I may be prosecuted.

I authorise and consent to any person who provides a medical service or hospital service to me in connection with an injury/condition to which this claim relates to provide upon request by the workers' compensation authority, my employer or insurer/claims agent or any committee established under legislation to advise the workers' compensation authority, any information regarding the service relevant to the claim. **I understand** that my authority has effect and cannot be revoked for the duration of this claim or any period where I am entitled to provisional payments.

Please note that there are penalties for providing false or misleading information in relation to this claim.

Worker's signature

Date 25/03/2025

7. Employer details

Employer to complete

This question is required to be completed on all claims

Claims with a mental injury – Early notification required

If the worker has indicated they have a mental injury (question 2), you must complete and forward Part A of this form to your Agent within **three business days** of receiving it from the worker.

While we encourage you to forward Part B together with Part A, you can choose to forward Part B separately but you **must forward Part B no later than 10 calendar days** after receiving Part A from the worker.

Are you forwarding Parts A and B together?*

☒ Yes

If you tick this box: the claim determination timeframe of 28 days will commence upon the Agent receiving both Part A and Part B from you.

If you do not tick this box: You are required to forward Part B within 10 calendar days of receiving Part A from your worker. The claim determination timeframe of 28 days will commence from the date the Agent receives Part B from you.

Please tick below if you have attached the following evidence to this form. I have attached evidence of:

☐ (a) the worker not being my worker

☐ (b) the claim being a duplicate claim

Please tick one or more where appropriate.

WorkSafe also encourages employers to provide early notification for physical injury claims.

* If you are a self-insurer, you do not need to answer this question.

When did you first receive the worker's completed claim form?

25/03/2025

Date forwarded to Agent: 25/03/2025

Employer's signature

Date 25/03/2025

Name

Saurav Kansakar

Position

Chief Financial Officer

Employer's scheme registration number
e.g. WorkCover Employer, Policy, or Employer Registration Number

15184335