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| This form is to be used if a worker sustains a work-related injury and has not completed a claim form. Employers are required to notify the insurer within 48 hours of an injury. The fields marked with a **grey asterisk** must be completed to be considered an “initial notification”. Please supply as much information as possible to allow us to make payments and develop an injury management plan. |
| 1. **Employer’s Details**
 |
| **\*** Business Name *(legal name)* |       |
| **\*** Contact Name: |       |
| **\*** Contact Number: |       | **\*** Contact Email: |       |
| Policy Number: |       | Cost Centre: |       |
| Business Address: |       |
| Suburb: |       | State: |       | Postcode: |       |
| 1. **Worker’s Details**
 |
| **\*** First Name: |       | **\*** Last name: |       |
| Gender: | [ ]  Male  | [ ]  Female | [ ]  Other |
| **\*** Address: |       |
| Suburb: |       | State: |       | Postcode: |       |
| **\*** Contact Number: |       | **\*** Email Address: |      Email address unknown [ ]  |
| Date of Birth: |       /       /       |
| Does the worker require a translator? | [ ]  Yes | [ ]  No | If yes, language |       |
| **\*** What is their occupation? |       |
| **\*** What is their employment status? | [ ]  Permanent Full Time[ ]  Permanent Part Time[ ]  Casual | [ ]  Apprentice / Trainee[ ]  Unknown |
| Do you have an available copy of the worker’s pay summary for the 52 weeks prior to the injury? |
| [ ]  Yes | Please provide a copy with this form |
| [ ]  No – *if you know the worker’s wage details please provide them here* | Hours per week |       | Base rate | $       |

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| 1. **Injury Details**
 |
| **\*** Injury Date: |       /       /       | Injury Time: | HH : MM : AM / PM |
| **\*** On what date was the injury reported to the employer? |       /       /       |
| **\*** Tell us briefly how the injury occurred: |       |
| **\*** What part of the body was injured? i.e., right foot, left shoulder |       |
| **\*** What type of injury is it? i.e., burn, sprain, cut |       |
| **\*** Accident location? | [ ]  At work performing normal duties[ ]  Travelling to another location for work[ ]  On their break[ ]  Travelling to work or home |
| 1. **Treatment Details**
 |
| **\*** Has the worker received any treatment for the injury other than simple first aid? |
| [ ]  Yes, please complete the following questions | [ ]  No, proceed to Section 5 |
| **\*** What treatment has the worker received for this injury? |       |
| **\*** Name of Doctor or Hospital: |       | Phone: |       |
| Address:  |       |
| **\*** Has the worker been issued with a medical certificate? | [ ]  Yes | Please provide a copy of the certificate with this form |
| [ ]  No | Proceed to Section 5 |

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| 1. **Notifier’s Details**
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| **\*** Are the details the same as the *Employer’s Details*? | [ ]  Yes | Please proceed to ‘What is your relationship to the worker?’ |
| [ ]  No | Please complete the following details |
| **\*** Notifier’s Name: |       | **\*** Contact Number: |       |
| **\*** Address: |       |
| **\*** What is your relationship to the worker? | [ ]  Employer[ ]  Worker[ ]  Medical Practitioner[ ]  Other – Employer’s representative[ ]  Other – Worker’s representative |
| Is there anything else you would like to tell us regarding the incident? |       |

**Please complete and return this form together with a copy of the worker’s pay summary for the 52 weeks prior to the injury and / or Medical Certificate if available to Trinity Insurance**:

**🖃:** GPO Box 4143, SYDNEY NSW 2001

**🖂:** newclaims@trinityinsurance.au

**:** 02 8251 9495