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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** | | | | | |
| **\*** 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