Initial Notification of Injury Form

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. Please select appropriate injury type *

☐ **Injury Notification:** Use this option if the worker has experienced an injury that requires medical treatment and/or time off from work or normal duties.

☐ **Notification of Incident Only**: Use this option if an incident occurred but no medical treatment or time off from work is required and the worker continues normal duties.

Opting for this will record this as an incident only. The employer will receive email correspondence including the incident number to provide to the worker, and the incident will be closed automatically.

2. Employer's Details

* Business Name *(legal name)*					
* Contact Name:					
* Contact Number:		* Contact Email:			
Policy Number:		Cost Centre/Venue			
Business Address:					
	Suburb:		State:		Postcode:

3. 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			
Employment Date					

GPO Box 4143, Sydney NSW 2001
trinityinsurance.au
T: 02 8251 9100
T: 1800 469 931
F: 02 8251 9495
E: info@trinityinsurance.au

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	$

4. Injury Details

* Injury Date:		Injury Time:	
* 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		

5. 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	

GPO Box 4143, Sydney NSW 2001
trinityinsurance.au

T: 02 8251 9100
T: 1800 469 931

F: 02 8251 9495
E: info@trinityinsurance.au

6. 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