

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 <i>(legal name)</i>				
* 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:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Other	
* Address:				
Suburb:		State:		Postcode:
* Contact Number:		* Email Address:		Email address unknown <input type="checkbox"/>
Date of Birth:				
Does the worker require a translator?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, language
* What is their occupation?				
* What is their employment status?		<input type="checkbox"/> Permanent Full Time	<input type="checkbox"/> Apprentice / Trainee	
		<input type="checkbox"/> Permanent Part Time	<input type="checkbox"/> Unknown	
		<input type="checkbox"/> Casual		
Employment Date:				

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

### 6. Notifier's Details

* Are the details the same as the <i>Employer's Details</i> ?	<input type="checkbox"/> Yes	Please proceed to 'What is your relationship to the worker?'		
	<input type="checkbox"/> No	Please complete the following details		
	* Notifier's Name:		* Contact Number:	
	* Address:			
* What is your relationship to the worker?	<input type="checkbox"/> Employer <input type="checkbox"/> Worker <input type="checkbox"/> Medical Practitioner <input type="checkbox"/> Other – Employer's representative <input type="checkbox"/> 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 Hospitality Industry Insurance:**

: GPO Box 4143, SYDNEY NSW 2001  
: newclaims@hii.au  
: 02 8251 9069