Racing NSW Insurance Fund
Level 7, 51 Druitt Street
SYDNEY. NSW. 2000
Tel. 02 9551 7500
Fax: 02 9551 7725

Jockey's Injury Claim Form

Injured Worker's Information:

1. This form is to be completed as soon as a work related injury has occurred and sent to Racing NSW within 48 hours **Fax: 02 9551 7725 or Email: workerscompensation@racingnsw.com.au**

2. Please send the following to Racing NSW; Worker's Injury Claim Form, WorkCover Certificate of Capacity, Wage - details, and any other relevant documentation in relation to this claim.

3. WorkCover and Racing NSW place high importance on workplace-based rehabilitation. You will be contacted soon by the case manager who will work with you to facilitate the early, safe and sustainable return to work of the worker.

4. All Sections of this form must be completed in black pen only.

1. Your Details

Surname:

First Name:

Other known or previous legal names

Email: _____

RNSW Licence ID: _____

Date of Birth: / /

Emergency Contact:

Name:

Phone Number:

Gender: (Please tick)

☐ Male ☐ Female

Residential street address:

Email:

Suburb:

Postcode:

Phone No:

Mobile No:

Please state your Nationality:

_____

Please state your Language spoken at home:

_____

Bank Details:

Financial Institution: **BSB:** **Account No.**

Pre- Injury Average Weekly Earnings: $

2. Injury Details:

What was the date and time that your injury occurred?

Date: / / **Time:** **AM/PM**

What happened and how were you injured?

Where did the injury occur? (Stable, racecourse, etc…)

If you were injured when riding track work, who was the trainer you were riding for at the time?

What part/s of the body was injured?

Have you previously suffered a similar injury before?
Give details of this injury:

When did you report the incident?

Date: / / **Time:** **AM/PM**

Was there a witness to your incident?

☐ Yes ☐ No

If Yes, please state:

Contact Name: _____ **Phone Number:** _____

Who did you report the incident to?

_____

Please provide the contact details for this person:

_____

_____

Did you require an ambulance? ☐ Yes ☐ No

Were you taken to hospital? ☐ Yes ☐ No

Hospital Name: _____

Have you returned to Work? ☐ **Yes** ☐ **No**

If you have answered NO, what is your current work capacity status? (E.g. Suitable Duties, Pre-Injury duties)

_____

_____

Checklist:

Have you provided:

1. **Payslips/ Proof of earnings for ALL employers** ☐
2. **Have you completed this claim form in full** ☐
3. **Have you provided a Work Cover Certificate of Capacity stating your fitness for work** ☐
4. **Any other relevant documentation for your injury** ☐
5. **Have you read the declaration and signed the claim form** ☐

3. 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 medial 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, any information regarding the service relevant to the claim. I understand that my authority has effect and cannot be revoked for the duration of the claim. I also authorise any person or authority to provide information regarding factual matters relevant to the claim.

I understand that if this claim results in my receiving weekly compensation payments, I am required to notify whomever is paying my benefits, if I commence employment with some other person, or in my own business, or of any change in my employment that affects my earnings, and that failure to do so is an offense.

Worker's signature: …… Date: / /