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

Secretary's Report of Injury

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. Employer Details:

Club Name:

Address:

Suburb: **Postcode:**

Contact Person: **Contact Number:**

Email address:

2. Injured Worker's Details:

Full name of worker: **Contact Number:**

Street address:

Suburb: **Postcode:**

Date of Birth: / /

Occupation : (e.g. Ground person, barrier attendant, other)

Gender: (Please tick)

☐ Male ☐ Female

Pre- Injury Average Weekly Earnings: $

Bank Details:

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

Trainer's Details (In Case of Injury to Trackwork Riders):

Trainer's Name:

Address:

Suburb: **Postcode:**

Contact Person: **Contact Number:**

3. Injury Information:

What was the date and time that the injury occurred?

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

What happened and how was the person injured?

Where did the injury occur?

When was the incident reported?

Date: / / Time: AM / PM

What part of the body was injured?

Was an ambulance required?

☐ **Yes** ☐ **No**

Was there a witness to the incident?

☐ **Yes** ☐ **No**

If Yes, please state:

Contact Name: _____

Phone Number: _____

Was the injured worker taken to hospital?

☐ **Yes** ☐ **No**

Hospital Name: _____

Do you have any concerns with this claim? ☐ **Yes** ☐ **No**

If yes, provide details: _____

Claim Confirmation Details:

I have read the information provided in this form. I declare that the information I have supplied in this form, and any attachments to this form, is true and correct and that no information has been suppressed or omitted from this report to the best of my knowledge. I understand that the making of a false or misleading statement concerning a claim is punishable by law and that I may be prosecuted.

Do you accept that your worker has had an injury/condition which is work-related and occurred while in your employment?

☐ **Yes** ☐ **No**

Name of Secretary: **……**

Secretary's signature: ……Date: / /