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

Worker'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 your employer or faxed to Racing NSW within 48 hours **Fax**: **02 9551 7725 or Email: workerscompensation@racingnsw.com.au**

2. Notify your employer as soon as possible that you have been injured at work

3. Please send the following to Racing NSW; Worker's Injury Claim Form, WorkCover Certificate of Capacity, Wage details, and any other relevant documentation

4. 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.

5. <u>All section of this form must be completed in black pen only</u>.

1. Your Details:

Surname:

First Name:

Date of Birth: / /

RNSW Licence ID:

Gender: (Please tick)

☐ Male ☐ Female

Emergency Contact:

Name: _____

Phone Number: _____

Residential street address:

Email:

Suburb:

Postcode:

Phone No:

Mobile No:

Are you a:

☐ **Stablehand** ☐ **Track work Rider** ☐ **Grounds Person** ☐ **Foreperson**

☐ **Other (Please State)** _____

Please state your Nationality:

_____

Please state your language spoken at home:

_____

Bank Details for Payments of Compensation:

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

Pre- Injury Average Weekly Earnings: $

2. Your Employer details:

Full name of your employer:

Name and Contact number of Employer:

Street address of your usual workplace:

What is your occupation for this employer?

Date of Commencement with this employer: / /

What are the duties and activities of your current role?

_____

_____

_____

Do you have secondary employment?

What are your duties and activities?

_____

_____

_____

Please provide a brief employment, qualifications and skills history

3. Your Injury Information:

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? E.g. Racecourse, Stable, Private Training Facilities etc.

What part 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**

Who did you report the incident to? Please provide the contact name and details for this person:

Contact Name: _____

Contact details: _____

Did you require an ambulance?

☐ Yes ☐ No

Were you taken to hospital?

☐ Yes ☐ No

Hospital Name: _____

Checklist:

Have you provided:

Payslips/ Proof of earnings for ALL employers ☐

Have you completed this claim form in full ☐

Have you provided a Work Cover Certificate of Capacity stating your fitness for work ☐

Any other relevant documentation for your injury ☐

Have you read the declaration and signed the claim form ☐

4. Authority to release Relevant 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 medical 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 someone 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: / /