Secretary's Report of Injury

Racing NSW, as a Specialised Insurer has engaged Gallagher Bassett as an independent claims manager to assist with the administration of workers compensation claims within the Racing NSW Insurance Fund.

*This form is to be completed as soon as a work related injury has occurred and sent without delay to Gallagher Bassett at **Email:** racingnsw@gbtpa.com.au **Post:** GPO Box 5474 Sydney NSW 2001 **Fax:** (02) 9464 7244

*Please complete all sections of the form and attach all relevant information that you may hold including Worker's Injury Notification Form, Certificate of Capacity from the treating doctor, wage-details and receipts or invoices for medical and related treatment.

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: / /