

GIO Workers Compensation – Australian Capital Territory

Initial Notification of Injury

This form may be used to notify GIO of a workplace injury or illness. Please notify GIO of any injury as soon as possible even if all of the information is not known.

Australian Capital Territory employers are legally required to notify GIO within 48 HOURS after becoming aware that a worker has sustained a workplace injury. The employer can notify GIO in the following ways:

- ▶ Phone: 02 6281 8806 If notification is provided by phone, the employer is legally required to also provide notice in writing within 3 days after the oral notification.
- ▶ Fax: 02 6282 9394
- ▶ Email: wclaimsact@gio.com.au

Note:

1. This is not a claim form. Completion and submission of claim forms are still required if a claim is lodged.
2. The employer is still required to maintain a Register of Injuries in the workplace.

Purpose of notification

Notification only Treatment costs only Time lost from work

Employer/notifier details

Policy number	<input type="text"/>	Claim number (if applicable)	<input type="text"/>
Name of employer (as appears on policy)			
<input type="text"/>			
ABN	<input type="text"/>	Cost centre (if applicable)	<input type="text"/>
Address			
<input type="text"/>			
		State	Postcode
		<input type="text"/>	<input type="text"/>

Injured worker details

Name of injured worker			
Title	<input type="text"/>	Surname	<input type="text"/>
		Given name(s)	<input type="text"/>
Date of birth	<input type="text"/>	Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
Occupation	<input type="text"/>	Employment type:	Full time <input type="checkbox"/> Part time <input type="checkbox"/> Casual <input type="checkbox"/>
Residential address			
<input type="text"/>			
		State	Postcode
		<input type="text"/>	<input type="text"/>
Home phone	<input type="text"/>	Mobile phone	<input type="text"/>

Notifier details

Date of notification to employer	<input type="text"/>	Time of injury (am/pm)	<input type="text"/>
Name of person making notification			
<input type="text"/>			



Notifier's relationship to worker/employer (e.g. employer's representative, solicitor etc)

Workplace contact name (if different to notifier)

Telephone

Fax

Email

Other information that may assist in the assessment of this claim (e.g. liability issues)

Injured worker remuneration details

Average weekly earnings (\$wk)

Average hours per week

Injury details

Date of injury

Time of injury (am/pm)

Address/location where injury occurred

State

Postcode

Brief description of incident

State

Postcode

Nature of injury (eg: laceration, anxiety attack)

Body part/s affected (eg: lower back, left ankle)

Has the worker suffered a previous similar injury?

If time lost, date
ceased work

Time ceased
work

Date of return to work (if applicable)

Current work fitness:

Unfit

Pre-injury duties

Suitable duties

Treatment details

Has the worker received medical treatment?

Yes

No

Doctor/hospital name (include address if known)

Telephone

Fax

Notifier's signature

Date

When completed, please return this form to:

Email: wccclaimsact@gio.com.au

Fax 02 6282 9394