

# Workers Compensation Act 1987 Initial Notification of Injury

Claim no.

:	:	:	:	:	:	:	:	:	:
---	---	---	---	---	---	---	---	---	---

Policy no.

:	:	:	:	:	:	:	:	:	:
---	---	---	---	---	---	---	---	---	---

**This form is to be used when a worker suffers a workplace injury or illness where workers compensation is or may be payable. Notify your Agent within 48 hours.  
Notify injuries without delay, even if all the information is not known.**

**Please complete this form in BLOCK letters and use a black pen.**

## 1. Worker's details

Family name

Given names

Date of birth

 /  / 

Sex  Male  Female

Address

<input type="text"/>	
<input type="text"/>	Postcode

Work telephone no.

 ( ) 

Mobile

Home telephone no.

 ( ) 

## 2. Employer's details

Company name

Location of business premises

<input type="text"/>	
<input type="text"/>	Postcode

Name of workplace contact, if known (eg. name of return to work coordinator)

Telephone no.

 ( ) 

## 3. Injury details

Description of incident (eg. slipped from ladder while painting the ceiling)

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

Description of injury (eg. concussion and broken right arm)

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

### 3. Injury details cont.

Date of injury

Has the injured worker returned to work

Yes  If Yes, state date returned

No  If No, estimate date of return

Don't know

### 4. Treating doctor's details

Doctor's name

Hospital name (if worker is hospitalised)

Telephone No.

### 5. Notifier's details

Name

Relationship to worker or employer

Address

  

Postcode

Work telephone no.

Mobile no.

Home telephone no.

**When completed fax to:**  
**Sydney Centre: 1300 666 406**  
**Wollongong Centre: (02) 4226 5937**  
**Tamworth: (02) 6767 2381**  
**Newcastle: (02) 4907 5299**

CGU Workers Compensation (NSW) Limited ABN 19 003 181 002.

GPO Box 9960 Sydney NSW 2001

Tel. 1300 666 506