Claim number

Agent for the NSW WorkCover Scheme

WORKERS COMPENSATION ACT 1987

JOURNEY CLAIM

This supplementary information is to be provided by a worker in respect of an injury received while on the daily or the other periodic journey between the worker's place of abode and place of employment or to any trade, technical or other training school, or otherwise in the course of their employment.

Please complete this form in BLOCK letters and use a black pen.
If further space is required, attach a separate page.

1 WORKER'S DETAILS

Family name

Given names

Date of birth

D D / M M / Y Y

Sex

Male Female

2 JOURNEY DETAILS

Date and time of accident

Date

D D / M M / Y Y

Time

H H : M M am pm

What mode of transport were you using? – eg. motor vehicle, public transport, walking

Where exactly did the accident occur?

Street

Suburb

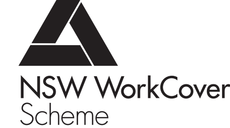
Postcode

Where were you travelling to? – eg. work, home, technical school

Where were you travelling from? – eg. work, home, technical school

What time did you leave work, home, technical school?

H H : M M am pm



JOURNEY DETAILS CONT...

Did you divert from your usual route? ☐ Yes ☐ No
If Yes, provide details

Was the journey broken for any reason? ☐ Yes ☐ No
If Yes, provide details

Had you consumed any alcohol or drugs in the 12 hours immediately prior to the accident? ☐ Yes ☐ No
If Yes, how much?

If you were a passenger, had the driver consumed any drugs or alcohol in the 12 hours immediately prior to the accident? ☐ Yes ☐ No

If Yes, how much?

If you were a driver/passenger, were you wearing a seat belt? ☐ Yes ☐ No

If you were a rider/passenger, were you wearing a helmet? ☐ Yes ☐ No

How did the accident occur?

Contact details of witnesses

Full name	Address	Phone number

In your opinion, who was responsible for the accident? Why?

JOURNEY DETAILS CONT...

Using the symbols below, draw a diagram of the accident scene showing the position of all vehicles and indicate by arrows the directions of travel.

Your vehicle

Other vehicle

Pedestrian, cyclist, etc.

Intersection

3 TRAFFIC ACCIDENT DETAILS

All traffic accidents must be reported to the police as soon as possible but no later than 28 days after the accident. If you have not reported your accident, you should do so immediately.

A IF YOU WERE INJURED IN A TRAFFIC ACCIDENT

Police station to which the accident was reported

Date reported D D / M M / Y Y

Police officer's name

Did police attend the accident? ☐ **Yes** ☐ **No** **Police reference number**

Police action taken or proposed

B ABOUT THE VEHICLE IN WHICH YOU WERE INJURED

Registration number

State of registration

Drivers licence number

Driver's name

Residential Address
Street

Suburb

Postcode

Phone

Work ( )

Mobile

Home ( )

Vehicle owner's name (if different from driver)

C OTHER VEHICLES INVOLVED (if more than two vehicles, attach a separate list)

Registration number

State of registration

Drivers licence number

Driver's name

Residential Address

Street

Suburb

Postcode

Phone

Work ( )

Mobile

Home ( )

Vehicle owner's name (if different from driver)

D CTP INSURER DETAILS

Have you made a personal injury claim against the person responsible? Yes No

If Yes, provide details

Name of CTP insurer

Claim/reference number

4 DECLARATION

I ____________________ PRINT NAME

certify that the information I have provided is true and correct. I understand that if any information I have given is untrue, my claim may be denied and I may be prosecuted. I understand that if this claim results in my receiving weekly workers compensation payments, I am required to notify whomever is paying my benefits if I commence employment with some 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 offence.

I expressly authorise any doctor, hospital, ambulance service, rehabilitaion or other medical or service provider engaged by me in connection with this claim to give my worker's compensation insurer copies of reports, clinical notes and records and any other health information and accounting data associated with my claim as the insurer may request.

I consent to my employer's workers compensation insurer and its appointed service providers collecting personal and health information about me and using it for the purposes of assessing and managing my workers compensation claim, including determining liability and whether my claim is true. I understand that my claim may not be able to be processed if I do not provide all of the required information.

I consent to my employer's workers compensation insurer disclosing my personal information to medical practitioners, rehabilitation providers, investigators, legal practitioners and other experts or consultants for use in assessing and managing my claim. I consent to my personal information being disclosed between these people for use in assessing and managing my claim.

I also consent to my employer's workers compensation insurer disclosing my personal details to the WorkCover Authority of NSW, which is authorised to use this information to perform its functions under the NSW workers compensation legislation. I consent to the WorkCover Authority of NSW using the information contained in this form for the purposes of research about workers compensation, workplace injury management or occupational health and safety. I understand that the information used in any such research, and the results of the research, will not contain any information that could be used to identify me.

I understand that I can request access to the information contained in this form from my employer's workers compensation insurer.

Signature of injured worker

Date D D / M M / Y Y