



Claim no.

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 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.

This form is also used for an injury received while away from work during a recess and for an injury involving a motor vehicle accident whilst working.

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

Sex

Male Female

Address

Suburb

Postcode

Phone

Mobile

Employer's name

Address

Suburb

Postcode

Phone

Fax

Email

2 JOURNEY DETAILS

Date and time of accident

Date / / Time : AM/PM

What mode of transport were you using?

eg. motor vehicle, public transport, walking, other

Where exactly did the accident occur? eg. street

Suburb

Postcode

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

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

Did the accident involve a motor vehicle whilst you were working?

Yes No

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

Were you on a recess or authorised break? Yes No

What is your usual route for this journey?

Did you divert from your usual route? Yes No

If Yes, provide details

Was there any interruption to the journey 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?

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How did the accident occur? Please provide a detailed description.

Contact details of witnesses

Full name	Address	Phone number

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

3 TRAFFIC ACCIDENT DETAILS

All traffic accidents in which someone is injured, 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 //

Police officer's name

Did police attend the accident? Yes No

Police reference number

Police action taken or proposed








If you were a driver/passenger, were you wearing a seatbelt?

Yes No

If you were a rider/passenger, were you wearing a helmet?

Yes No

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		

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B. ABOUT THE VEHICLE IN WHICH YOU WERE INJURED

Registration number State of reg.

Driver's name

Driver's licence number

Residential address: Street

Suburb Postcode

Phone: Work

Phone: Mobile

Phone: Home

Vehicle owner's name (if different from driver)

Vehicle owner's contact details (if different from driver)

C. OTHER VEHICLES INVOLVED

(if more than two vehicles, attach a separate list)

Registration number State of reg.

Driver's name

Driver's licence number

Residential address: Street

Suburb Postcode

Phone: Work

Phone: Mobile

Phone: Home

Vehicle owner's name (if different from driver)

Vehicle owner's contact details (if different from driver)

4 NON WORKERS COMPENSATION CLAIMS

Have you made a personal injury claim other than a workers compensation claim regarding this accident?

Eg. a CTP claim or a public liability claim Yes No

If Yes, provide details including the type of claim

Name of insurer

Claim/reference number

5 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 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 this claim.

I authorise and consent to the collection, disclosure and release of any personal and health information in connection with an injury/condition to which this claim relates. I understand that if this claim results in me receiving weekly 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 consent to the WorkCover Authority of NSW using the information collected in connection with my claim for the purposes of research about workers compensation, workplace injury management and occupational health and safety.

Signature of injured worker

Date / /