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Worker's Recurrence Report of Injury Form Following Return to Normal Duties

This form is to be completed by the worker for a recurrence of an original injury / illness, after normal duties have been resumed. This form must be submitted to and signed off by your employer.

1. Employee Details

Name ______________________ Claim number ☐☐☐☐☐☐☐☐☐☐☐☐☐

Address ______________________

Post code __________ Home phone __________ Date of original injury / /

Date of recurrence / / Date returned to duties / /

Employer at date of original injury ______________________

2. Recurrence Details

1. How does this recurrence relate to your original injury/illness?

____

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2. Is this recurrence in the same part of your body as your original injury/illness? ☐ Yes ☐ No

Please specify ______________________

____

3. In your own words, how did this recurrence occur? (eg. specific incident / gradual onset of pain)

____

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4. When you returned to work, did you experience any discomfort or symptoms undertaking those duties?

☐ Yes ☐ No. If Yes, please specify ______________________

____

Has your discomfort/symptoms continued? ☐ Yes ☐ No

If Yes, please give details ______________________

____

Briefly describe details of current treatment you are having ______________________

____

3. Employee Consent Declaration

Employee signature ______________________ Date / /

Employer signature ______________________ Date received by employer / /

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