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Lodgement Form

Report an incident or injury
Injured person lodgement

This form has been specifically designed for completion by an injured person for an incident that occurred at work. Employers and other third party representatives are requested to complete the employer/third party representative lodgement form.

Fields marked with an * need to be completed for your form to be submitted, however please provide as much information as you can.

1. Tell us about the injured person

Injured person's first name*

Injured person's last name*

Injured person's best contact number*

Injured person's email*

Injured person's date of birth (DD/MM/YYYY)*

Injured person's gender*

☐ Male ☐ Female ☐ Other ☐ Prefer not to say

Address (street and number)*

Suburb/Town*

State*

Postcode*

Postal address (if not the same as residential)

Suburb/Town

State

Postcode

Does the injured person require an interpreter

☐ Yes ☐ No

If yes, what is the preferred language

2. Tell us about the injury

Date of injury (DD/MM/YYYY)*

Time of injury (HH:MM)*

Name of person the injury was reported to*

Date employer was notified (DD/MM/YYYY)*

Did the injury occur whilst performing normal work activities* ☐ Yes ☐ No

Does the injured person have multiple injuries* ☐ Yes ☐ No

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Tell us briefly about how the injury occurred*

Which general area of the body has been injured? If the injured person has multiple injuries, please indicate the most significant injury in this section*

Where specifically is the injury*

What is the type of injury? An injury type could be a cut, a broken bone, anxiety, depression or other*

Is the injured person currently admitted to hospital due to their injury ☐ Yes ☐ No

Is medical treatment required* ☐ Yes ☐ No

Does the injured person feel in control of their pain and/or recovery ☐ Yes ☐ No

Has the injured person had time off work because of the injury ☐ Yes ☐ No

If so, what date did the injured person stop work (DD/MM/YYYY)

Has the injured person returned to work* ☐ Yes ☐ No

If the injured person remains off work, how long do you anticipate the injured person being off work

☐ 0–2 weeks ☐ 2–4 weeks ☐ 4+ weeks ☐ Uncertain

Will the injured person be able to use their normal mode of transport to and from work

☐ Yes ☐ No

Please tell us more about this

Does the injured person have support at work and in their home life ☐ Yes ☐ No

Does the injured person have any additional health conditions ☐ Yes ☐ No

Does the injured person have any additional health conditions we need to be aware of

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3. Injured person's work details

Workers compensation policy number

Employer's ABN

Employer's company or business name*

Employer's contact name

Address (street and number)

Suburb/Town

State

Postcode

Employer's best contact number

Employer's email

Injured person's commencement date of employment

Injured person's occupation

Injured person's average weekly wage (excluding shift allowances and overtime earnings)

What are the ordinary number of hours worked per week (excluding overtime hours)

4. Injured person's bank details. Please provide details in case of reimbursement.

Account name

BSB

Account number

5. Supporting documents

Please attach additional documents to support your injury notification.

- ☐ Certificate of capacity (e.g. Medical certificate)
- ☐ Medical details (e.g. Medical related invoices or receipts, reports, scans)
- ☐ Wage details (e.g. Wage summary, pay slips, pre-injury average weekly earnings (PIAWE) form, wage reimbursement request)
- ☐ Other types of documents e.g. Return to work plan
- ☐ I agree with the Privacy Policy. To view the Privacy Policy online, please go to: **https://www.icare.nsw.gov.au/privacy/your-privacy**

Injured person's signature

Date (DD/MM/YYYY)

Once completed, please send your form to **newpiclaims@icare.nsw.gov.au**