GIO WORKERS COMPENSATION – AUSTRALIAN CAPITAL TERRITORY

Initial Notification of Injury

This form may be used to notify GIO of a workplace injury or illness. Please notify GIO of any injury as soon as possible even if all of the information is not known.

Australian Capital Territory employers are legally required to notify GIO within 48 HOURS after becoming aware that a worker has sustained a workplace injury. The employer can notify GIO in the following ways:

- Phone: 02 6281 8806 If notification is provided by phone, the employer is legally required to also provide notice in writing within 3 days after the oral notification.
- Fax: 1300 725 840
- Email: wcclaimsact@gio.com.au

Note:

1. This is not a claim form. Completion and submission of claim forms are still required if a claim is lodged.
2. The employer is still required to maintain a Register of Injuries in the workplace.

Purpose of notification

Notification only ☐ Treatment costs only ☐ Time lost from work ☐

Employer/notifier details

Policy number ______ Claim number (if applicable) ______

Name of employer (as appears on policy)

______

ABN ______ Cost centre (if applicable) ______

Address

______

Surburb State Postcode

Injured worker details

Name of injured worker

Title ______ Surname ______ Given name(s) ______

Date of birth / / Gender Male ☐ Female ☐

Occupation ______ Employment type: Full time ☐ Part time ☐ Casual ☐

Residential address

______

Surburb State Postcode

Home phone ( ) Mobile phone ( )

Notifier details

Date of notification to employer / / Time of injury (am/pm) ______

AAI Limited ABN 48 005 297 807 trading as GIO – Agent for the Workers Compensation Nominal Insurer ABN 83 564 379 108/003 also known as icare workers insurance.
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Name of person making notification

Notifier's relationship to worker/employer (e.g. employer's representative, solicitor etc)

Workplace contact name (if different to notifier)

Telephone ( ) Fax ( )

Email

Other information that may assist in the assessment of this claim (e.g. liability issues)

Injured worker remuneration details

Average weekly earnings ($wk) $ Average hours per week

Injury details

Date of injury / / Time of injury (am/pm)

Address/location where injury occurred

Surburb State Postcode

Brief description of incident

Surburb State Postcode

Nature of injury (eg: laceration, anxiety attack)

Body part/s affected (eg: lower back, left ankle)

Has the worker suffered a previous similar injury?

If time lost, date ceased work / / Time ceased work Date of return to work (if applicable) / /

Current work fitness: Unfit ☐ Pre-injury duties ☐ Suitable duties ☐

Treatment details

Has the worker received medical treatment? Yes ☐ No ☐

Doctor/hospital name (include address if known)

Telephone ( ) Fax ( )

Notifier's signature Date / /

When completed, please return this form to:

Email: wcclaimsact@gio.com.au Fax: 1300 725 840