QBE INSURANCE (AUSTRALIA) LIMITED
ABN 78 003 191 035
Canberra Branch
Level 2, 33 Ainslie Avenue
Canberra City ACT 2601
PO Box 1008, Civic Square ACT 2608
Tel: 02 6240 3434
Fax: 02 6249 8633

ACT Notification and Register of Injury Form

INCIDENT NUMBER

This form must be forwarded to QBE within 48 hours of a worker notifying the employer of an injury or within 3 days of an employer notifying QBE by telephone of an injury.

Worker's Details

Surname

Given Name

Home Address

Postcode

Telephone – Home

Telephone – Work

Date of Birth

/ /

Male ☐ Female ☐

Occupation

Industry

Is interpreter required? Yes ☐ No ☐ If yes, please specify language

Employer's Details

Business Name

Policy Number *(if known)*

ABN

Address

Postcode

Telephone

Fax

Contact Person for this Report

Work Telephone

Fax

Mobile

Email

Date of Notification by Worker

/ /

If someone made the notification on the worker's behalf, please provide:

Name

Telephone

Injury Details

Date of Injury

/ /

Time

am/pm

Where did injury occur (location)?

What body part(s) were injured or affected?

What injury or disease was suffered?

How did the injury happen?

Has the cause of the injury been investigated? Yes ☐ No ☐

Has remedial action been taken to prevent another injury? Yes ☐ No ☐

Has the worker returned to work? ☐ Yes - Normal Duties ☐ Yes - Suitable Duties ☐ No - Time lost to date ____ days

If worker has not returned to work, what is the date of expected return to work? / /

Treatment Details

Was First Aid provided for this injury? ☐ Yes - By whom? ☐ No

Was referral made for other treatment? ☐ Yes - To whom? ☐ No

Name of Treating Doctor

Address

Postcode

Telephone

Fax

Is a Medical Certificate available? ☐ Yes *(please fax through with this form)* ☐ No

The Privacy legislation protects personal and sensitive information on this form that could reasonably identify you to another person. QBE will only use or disclose our personal information for purposes that would reasonably be expected during the claim process. We may need to share your information with our agents or service providers who may also be involved with your claim. This could include rehabilitation providers, medical practitioners, investigators, solicitors, other insurers, and national and overseas reinsurers. If we need to use the information for another purpose, we will ask you for your permission first. You will be provided with the opportunity to access your personal information (some restrictions and costs may apply). In respect of any complaint that you may have regarding your personal information, QBE will provide you with our dispute resolution procedures. If you would like any further information or if you have any concerns about how QBE is managing your personal information, please contact the Compliance Manager by email: compliance.manager@qbe.com or by telephone: (02) 9375 4656.

Name of Person registering injury details

Position

Signature

Date / /

Name of Witness

Position

Contact Details (telephone/address)

Please fax this form immediately to QBE Workers' Compensation on 6249 8633

Internal Use Only

Received By

Date / /

Time am/pm

Case Manager

Claim No.