Racing NSW Insurance Fund
Level 7, 51 Druitt Street
SYDNEY. NSW. 2000
Tel. 02 9551 7500
Fax: 02 9551 7725

Employer's Injury Claim Form

Injured Worker's Information:

1. This form is to be completed as soon as a work related injury has occurred and sent to Racing NSW within 48 hours **Fax: 02 9551 7725 or Email: workerscompensation@racingnsw.com.au**

2. Please send the following to Racing NSW; Worker's Injury Claim Form, WorkCover Certificate of Capacity, Wage - details, and any other relevant documentation in relation to this claim.

3. WorkCover and Racing NSW place high importance on workplace-based rehabilitation. You will be contacted soon by the case manager who will work with you to facilitate the early, safe and sustainable return to work of the worker.

4. **All Sections of this form must be completed in black pen only**.

1. Employer Details:

Trainer/ Company Name/ Club Name:

Address:

Suburb: **Postcode:**

Contact Person: **Contact Number:**

Email address: **RNSW Licence ID:**

2. Employee Details:

Full name of worker: **Contact Number:**

Street address:

Suburb: **Postcode:**

Occupation:
E.g. Track work rider, Stable hand, other

RNSW Licence ID:

Date of Birth: / /

Marital Status: (Please tick)

☐ Single ☐ Married/Defacto

Gender: (Please tick)

☐ Male ☐ Female

Current Duties:

- _____
- _____
- _____
- _____
- _____

Please identify suitable duties or alternative duties that may be available:

- _____
- _____
- _____
- _____
- _____

Is the worker:

☐ **Casual**

☐ **Permanent**

☐ **Part-time**

Are you aware if the worker has other employment?

☐ **Yes** ☐ **No**

If yes, state where _____

_____

Gross Pre-injury Average Weekly Earnings:

$ _____

Hours worked per week:

_____

3. Injury Information:

What was the date and time that the injury occurred?

Day: **Date:** / / **Time:** **AM/PM**

What happened and how was the person injured?

Where did the injury occur?
E.g. Racecourse, Stable, Private Training Track

What part of the body was injured?

When was the incident reported?

Date: / / **Time:** **AM/PM**

Was there a witness to the incident?

☐ **Yes** ☐ **No**

If Yes, please state:

Contact Name: _____

Phone Number: _____

Who was the injury reported to? Please provide the contact name and details for this person:

_____

_____

Was an ambulance required?

☐ **Yes** ☐ **No**

Was the injured worker taken to hospital?

☐ **Yes** ☐ **No**

Hospital Name: _____

Has the worker returned to work?

☐ **Yes** ☐ **No**

What duties are they performing and what hours are they working?

_____

_____

_____

Do you have any concerns with this claim? ☐ **Yes** ☐ **No**

If yes, provide details: _____

Checklist:

Have you provided:

1. **Payslips/ Proof of earnings** ☐
2. **Claim form in full** ☐
3. **WorkCover Certificate of Capacity stating fitness for work** ☐
4. **Any other relevant documentation for their injury** ☐
5. **Have you read the declaration and signed the claim form** ☐

Claim Confirmation Details:

I have read the information provided in this form. I declare that the information I have supplied in this form, and any attachments to this form, is true and correct and that no information has been suppressed or omitted from this report to the best of my knowledge. I understand that the making of a false or misleading statement concerning a claim is punishable by law and that I may be prosecuted.

Do you accept that your worker has had an injury/condition which is work-related and occurred while in your employment?

☐ **Yes** ☐ **No**

Employer's signature: **……** Date**:** / /