

## Employer's Injury Notification Form

Racing NSW, as a Specialised Insurer has engaged Gallagher Bassett as an independent claims manager to assist with the administration of workers compensation claims within the Racing NSW Insurance Fund.

\*This form is to be completed as soon as a work related injury has occurred and sent without delay to Gallagher Bassett at

Email: [racingnsw@gbtpa.com.au](mailto:racingnsw@gbtpa.com.au) Post: GPO Box 5474 Sydney NSW 2001 Fax: (02) 9464 7244

\*Please complete all sections of the form and attach all relevant information and documentation including Worker's Injury Notification Form, WorkCover Certificate of Capacity, wage-details and receipts or invoices for medical and related treatment.

\*Shortly after lodgement you will be contacted by your case manager who will provide all ongoing claim and injury management assistance.

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: / /