

Section C – Employer's Statement (Must be completed by your employer payroll/manager only)

Please ensure a **full 12 month wage report** prior to the disablement is attached with this form.

Please also ensure a **job description** outlining the employee's regular pre-disability occupational duties is attached with this form.

Employee's Details

Employee's name			Employee number		
Employee's Job Title					
Description of Injury or Sickness					
Employment type	☐ Full-Time ☐ Part-Time ☐ Casual ☐ Contractor ☐ Project Specific Work				
Current work status	☐ Employed ☐ Resigned ☐ Terminated			Date Ceased	
Date commenced employment			Date of Injury or Sickness		
Date last actively at work			Date incapacity commenced		
Was the employee on alternative duties prior to the incapacity date?			☐ Yes ☐ No If "Yes", from when?		
Expected return to work date			Employee's gross weekly earnings	\$	
If the employee is fit for alternative duties are you prepared to take the employee back on alternative duties?				☐ Yes ☐ No	
In respect of this condition has your company completed any forms to any other insurance companies, workers compensation insurer or government benefit entities?				☐ Yes ☐ No	
If "Yes", please advise when and to which company					
Has the employee received any employer entitlements (normal pay, sick leave, annual leave etc.) since the incapacity commenced?				☐ Yes ☐ No	
If "Yes" please complete details below and provide an additional wage report for the period					
TYPE OF EMPLOYER BENEFIT	AMOUNT RECEIVED	DATE RECEIVED FROM	DATE RECEIVED TO		
Do you believe the employee's condition is work related?		☐ Yes ☐ No			
Does your company provide an EBA Income Protection policy?		☐ Yes ☐ No	Insurer		
Is your company self-insured for workers compensation?		☐ Yes ☐ No			
Is the employee currently on workers compensation?		☐ Yes ☐ No			
Does your company top-up workers compensation claims?		☐ Yes ☐ No			
Name of Workers Compensation			Policy No.		
If employee was employed on a specific work project	Project Name				
Date commenced work on project			Completion date of project		
Estimated Employment Completion Date of Injured/ Sick Employee (Employee estimated demobilisation date?)					

Occupational Questionnaire

The following questions are in relation to your employee's regular occupation and typical duties performed.

Please advise pre-disability hours and days	
Please provide details of the environment in which they work	
Are there any special skills, qualifications or licences required to perform their current occupation? Please specify	

