

Section 2 – Claimant's/event details (whether claimant is worker or a dependent of a deceased worker)

3. Title: (please select)	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Dr <input type="checkbox"/> Other _____		
4. Surname or family name:			
5. Given or first name/s:			
6. Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	7. Date of birth:	DD / MM / YYYY
8. Residential address of the claimant:	Unit/Building no.	Street no.	Street name
	Suburb/Town/Locality		State Postcode
9. Has the claimant ever been known by another name?			<input type="checkbox"/> Yes (see below) <input type="checkbox"/> No
Surname or family name:			
Given or first name/s:			

Worker's details (if worker different from claimant)			
10. Title: (please select)	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Dr <input type="checkbox"/> Other _____		
11. Surname or family name:			
12. Given or first name/s:			
13. Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	14. Date of birth:	DD / MM / YYYY
15. Residential address of worker at time of event:	Unit/Building no.	Street no.	Street name
	Suburb/Town/Locality		State Postcode
16. Has the worker ever been known by another name?			<input type="checkbox"/> Yes (see below) <input type="checkbox"/> No
Surname or family name:			
Given or first name/s:			

Please note: if a dependency claim (i.e. the injury resulted in the worker's death), complete all relevant questions for each claimant from questions 17 to 33.

If claimant is the deceased worker's spouse	
17. Date of marriage:	DD / MM / YYYY
18. Place of marriage:	

(If you have completed this question, go to question 21.)

If claimant is the deceased worker's de facto			
19. Date on which de facto relationship started:	DD / MM / YYYY		
20. Residential address where de facto relationship first started:	Unit/Building no.	Street no.	Street name
	Suburb/Town/Locality		State Postcode

If claimant is the deceased worker's spouse or de facto	
21. Details of any health problems currently suffered by the claimant:	
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22. Expected date of birth of any posthumous child/children of the relationship with the worker:		DD / MM / YYYY
23. Has claimant married, remarried or entered into a marriage-like relationship since the worker's death?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, date of marriage:	DD / MM / YYYY	
24. Was the claimant receiving an income before the worker's death?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, give net (after tax) weekly income from all sources:		
\$	Source	
\$		
\$		
\$		
\$		
\$		
\$		
\$		
\$		
\$		
\$		
25. Was the claimant receiving an income after the worker's death?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, give net (after tax) weekly income from all sources:		
\$	Source	
\$		
\$		
\$		
\$		
\$		
\$		
\$		
\$		
\$		
26. What was the amount of average weekly financial benefit derived by the claimant from the deceased worker before the worker's death and the method of calculating the amount?		\$
Method of calculation:		
27. Did the claimant intend working?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, to what age?		
28. Was the intended future employment full- or part-time?		<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time

(If claimant has completed this question, go to question 34.)

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If claimant is not the deceased worker's spouse or de facto

29. Relationship to deceased worker:

30. Details of any health problems currently suffered by the claimant:

31. What are the claimant's current net (after tax) weekly earnings?

\$	Source
\$	
\$	
\$	
\$	
\$	
\$	
\$	
\$	
\$	
\$	

32. What was the amount of average weekly financial benefit derived by the claimant from the deceased worker before the worker's death and the method of calculating the amount? \$

Method of calculation:

33. Would the claimant have been dependent on the deceased worker? Yes No

If Yes, to what age?

Basis for dependency:

Worker's employment details at date of event

34. Usual occupation: Full-time Part-time

35. Nature of employment at time of event (if different from usual occupation)

WHSQ12285

36. Details of every employer of the worker at the time of the event (include details of self-employment):			
Trading name of employer:			
Business address:	Unit/Building no.	Street no.	Street name
	Suburb/Town/Locality		State Postcode
Trading name of employer:			
Business address:	Unit/Building no.	Street no.	Street name
	Suburb/Town/Locality		State Postcode

Details of the event resulting in the 'injury'

37. Date and time of event	DD / MM / YYYY	Time:	<input type="checkbox"/> am <input type="checkbox"/> pm
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38. If over period of time, state:

When the duties resulting in the injury commenced:	DD / MM / YYYY	When symptoms commenced:	DD / MM / YYYY
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39. Where did the event happen? (e.g. workshop floor, Smith Street, Bulimba)	Place		
	Street no.	Street name	
	Suburb/Town/Locality		State Postcode

40. Completely describe the details of the event resulting in the injury:

41. Details of employer's representative to whom injury was reported:

Name:			
Position:			
Address:	Unit/Building no.	Street no.	Street name
	Suburb/Town/Locality		State Postcode

Witnesses

42. Was the event witnessed? (provide details of all witnesses)	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Witness 1

Surname or family name:			
Given or first name/s:			
Address:	Unit/Building no.	Street no.	Street name
	Suburb/Town/Locality		State Postcode
What is the relationship, if any, of the witness to the worker?			

Witness 2

Surname or family name:			
Given or first name/s:			
Address:	Unit/Building no.	Street no.	Street name
	Suburb/Town/Locality		State Postcode
What is the relationship, if any, of the witness to the worker?			

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43. Particulars of all injuries alleged to have been sustained because of the event (it is not a requirement to complete the Notice of Assessment column, however it will assist in responding promptly to the Notice of Claim).

Part of the body injured (e.g. right index finger, lower back)	Nature of injury/ies (e.g. fracture, strain)	Degree of permanent impairment alleged to have resulted from the injury/ies	Has a Notice of Assessment (or Damages Certificate) been received?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

44. List all doctors, hospitals, rehabilitation and any other service providers from whom the worker received treatment for the injury arising out of the event.

Doctor/hospital name	Address

45. Has the worker sustained any other personal injury/ies, illness/es or impairment/s of a medical, psychiatric or psychological nature, either before or since the event, that may affect the degree of permanent impairment resulting from the injury to which the claim relates?

Yes (complete table below)
 No

Injury, illness or impairment	Doctor/hospital name	Address

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46. Has the worker sustained any other personal injury/ies, illness/es or impairment/s of a medical, psychiatric or psychological nature, either before or since the event, that may affect the amount of damages in any way? Yes (complete table below) No

Injury, illness or impairment	Doctor/hospital name	Address

47. Has the worker ever made a claim, either before or since the event, for damages, compensation or benefits as a result of any other personal injury/ies, illness/es or impairment/s of a medical, psychiatric or psychological nature? Yes (complete BOTH tables below) No

Injury, illness or impairment	Name and address of insurer	Name and address of organisation or person against whom claim was made

Injury, illness or impairment	Doctor/hospital name	Address

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48. How is the worker presently affected by the injury/ies?

(e.g. symptoms suffered, effect at work and away from work. If not affected, write 'nil'.)

Mitigation

49. Has the worker been provided with an assessment or provision of treatment or rehabilitation services? (e.g. work training, counselling, independent living assistance, exercise program)

Exclude details of any rehabilitation provided during the statutory claim as the insurer has this information.

Yes (*complete table below*)

No

Treatment	Name	Address

50. Provide particulars of all steps, other than rehabilitation, taken by the worker to mitigate loss.

(e.g. search for work, consulting employment agency, re-training)

Section 4 – Liability

52. Did the worker cause, or contribute to, the event causing the injury?		<input type="checkbox"/> Yes <input type="checkbox"/> No						
53. To what extent of liability on the part of the worker, expressed as a percentage, does the claimant admit?		%						
If the claimant cannot admit liability, provide reasons:								
<hr/> <hr/> <hr/> <hr/> <hr/>								
54. Provide the full particulars of any negligence alleged against the worker's employer:								
<hr/> <hr/> <hr/> <hr/> <hr/>								
55. To what extent of liability, expressed as a percentage, does the claimant hold the employer/s responsible?		%						
56. Is negligence alleged other than against the worker's employer/s? (If yes, complete below and questions 57–59).		<input type="checkbox"/> Yes <input type="checkbox"/> No						
Name:								
Address:								
<table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">Unit/Building no.</td> <td style="width: 33%;">Street no.</td> <td style="width: 34%;">Street name</td> </tr> <tr> <td>Suburb/Town/Locality</td> <td>State</td> <td>Postcode</td> </tr> </table>			Unit/Building no.	Street no.	Street name	Suburb/Town/Locality	State	Postcode
Unit/Building no.	Street no.	Street name						
Suburb/Town/Locality	State	Postcode						
57. Provide the full particulars of any negligence alleged:								
<hr/> <hr/> <hr/> <hr/> <hr/>								
58. To what extent of liability, expressed as a percentage, does the claimant hold that party responsible?		%						
59. If negligence is alleged other than against the worker's employer, has notice of the alleged negligence been given?		<input type="checkbox"/> Yes <input type="checkbox"/> No						
If Yes, date notice given:	DD / MM / YYYY							
Name and address of person to whom notice given:								
Name:								
Address:								
<table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">Unit/Building no.</td> <td style="width: 33%;">Street no.</td> <td style="width: 34%;">Street name</td> </tr> <tr> <td>Suburb/Town/Locality</td> <td>State</td> <td>Postcode</td> </tr> </table>			Unit/Building no.	Street no.	Street name	Suburb/Town/Locality	State	Postcode
Unit/Building no.	Street no.	Street name						
Suburb/Town/Locality	State	Postcode						

Section 6 – Declaration (where date of injury is on or after 1 February 1997 and before 1 July 2001)

I, _____
Name of claimant

Declare under the *WorkCover Queensland Act 1996* that to the best of my knowledge and belief the statements of fact contained in this Notice of Claim for Damages are true, correct and complete in every respect.

Claimant's signature

Declared before me:

Signature of Justice of the Peace or Commissioner for Declarations or Solicitor

Date DD / MM / YYYY at _____ (place)

Justice of the Peace or Commissioner for Declarations or Solicitor (see below)

Name:			
Address:	Unit/Building no.	Street no.	Street name
	Suburb/Town/Locality		State Postcode
Telephone:			

Section 7 – Declaration (where date of injury is on or after 1 July 2001)

I, _____
Name of claimant

Declare under the *WorkCover Queensland Act 1996* that all statements made in this Notice of Claim for Damages that are in my personal knowledge, are true, correct and complete in every respect.

Claimant's signature

Declared before me:

Signature of Justice of the Peace or Commissioner for Declarations or Solicitor

Date DD / MM / YYYY at _____ (place)

Justice of the Peace or Commissioner for Declarations or Solicitor (see below)

Name:			
Address:	Unit/Building no.	Street no.	Street name
	Suburb/Town/Locality	State	Postcode
Telephone:			

Where a lawyer may sign: A lawyer may sign on behalf of the claimant **only where there is an urgent need to commence proceedings AND where it is not reasonably practicable for the claimant to sign.**

I, _____
legal representative of the claimant, _____
sign this Notice of Claim on behalf of the claimant because it is not reasonably practicable for the claimant to do so.

Signature

Lawyer's contact details

Name of firm:			
Address:	Unit/Building no.	Street no.	Street name
	Suburb/Town/Locality	State	Postcode
Telephone:			

Privacy statement:

The Office of Industrial Relations respects your privacy and is committed to protecting personal information. The information will be managed within the requirements of the current state government privacy regime. The Office of Industrial Relations uses your personal information for the purposes for which it was collected and will not disclose it to a third party without your consent unless required or authorised to do so by law. Further information on our privacy policy is available at worksafe.qld.gov.au.

This form was approved by the Workers' Compensation Regulator, on 1 May 2014, pursuant to section 586 of the *Workers' Compensation and Rehabilitation Act 2003*.