



SURF LIFE SAVING NEW SOUTH WALES INC.

NOTIFICATION OF INJURY FORM

This form is to be completed when a volunteer suffers an injury or illness where compensation is or may be payable under the Workers Compensation Emergency and Rescue Act 1987. This form must be submitted within 48 hours upon notification of intent to claim.

Procedure

In order to process a workers compensation claim quickly, attention should be given to the following:

1. The injured club member should immediately notify their supervisor in the event of any injury or illness. It is vital that this injury/illness is **entered into the logbook** and then into the **Incident Reporting Database (IRD)** by a nominated club authority.
2. Complete this **Notification of Injury Form** (if claiming workers compensation benefits) and fax it to WorkCover on 02 9287 4828.
3. If your injury has or will result in you being away from your paid employment for 7 days or greater, you will need to contact WorkCover immediately (1800 221 960) to advise of your injury;
4. If required by WorkCover NSW, the **injured club member** (or guardian if under 18) is to complete the Workers Compensation Claim Form.

Scope of Cover

The Cover under WorkCover is limited to compensation payable as described in the Workers compensation (Bush Fire, Emergency and Rescue Services) Act 1987, whilst the member is acting in their capacity as a Surf Lifesaver. The cover extends to official duties anywhere in Australia. All Surf Lifesaving activities may need to be verified by proof of entry to competition, patrol roster, volunteer roster, patrol log book, IRB log book, radio log book etc. Training and competition can only be at authorised and organised sessions. Members who compete in elite events where prize money is paid or professional sportspersons or competitors, who compete in events not under the control of the SLSA, may need to take separate insurance/workers compensation.

WorkCover may require the claimant to attend a medical examination by a doctor nominated by the Authority. Dependent on claim complexity, additional information may be sought by WorkCover.

Approval for any medical treatment is to be obtained from WorkCover NSW prior to the commencement of treatment, unless the treatment has been provided in the case of an emergency.

Who was injured?

Title: Mr Mrs Ms Miss Other Male Female

Surname: _____ Date of Birth: _____

Given names: _____

Street No. and Name: _____

Suburb/Town: _____

State: _____ Post Code: _____ Phone: _____

Details of Injury

When did your injury occur? Date: _____ Time: _____

What part(s) of your body were affected from your injury/condition (i.e. left/right broken wrist)?

Type of accident

- | | | |
|--|--|---|
| <input type="checkbox"/> Sprain/Strain | <input type="checkbox"/> Dental | <input type="checkbox"/> Fracture/Dislocation |
| <input type="checkbox"/> Broken bone | <input type="checkbox"/> Spinal Injury | <input type="checkbox"/> Laceration |
| <input type="checkbox"/> Other, please specify _____ | | |

What happened to cause your injury/condition?

What caused the injury?

- IRB Surf Ski Surf Board Surf Boat
- Patrol duties Competing Training Rescue
- Other, please specify _____

Membership Details

Club status (i.e. member, Club Captain, Patrol Captain): _____

Name of Club/Branch: _____

Name of person completing this form: _____

Medical Treatment

Did you receive any medical treatment? Yes No

Are you currently having medical treatment for this injury/illness? Yes No

If yes, please provide details of the doctor and/or hospital you obtained/is obtaining treatment from:

Doctor/Hospital: _____

Address: _____

Phone: _____ Medical Certificate attached? Yes No

Time Lost

Have you lost any time from your paid employment as a result of this injury? Yes No

If yes, who is your employer? _____

If yes, what is your occupation? _____

Where to get help with this form: If you need assistance in completing this form, you can contact the Surf Life Saving NSW's Awards and WorkCover Officer on 6550 1132.

Declaration

I have read the information provided in this form. I declare that the information that I have supplied in this form, and any attachments to this form, is true and correct to the best of my knowledge. I understand that the making of a false or misleading notification or false or misleading statement in support of the notification is punishable by law and that I may be prosecuted.

I authorise and consent to the collection, disclosure and release of any personal and health information in connection with an injury/condition to which the notification relates by the WorkCover Authority of NSW or my volunteer organisation to each other, or to any person who provides a medical service or hospital service to me in connection with an injury/condition to which this notification relates. I understand that if this notification results in my receiving weekly compensation payments, I am required to notify whoever is paying my benefits if I commence employment with some other person or in my own business, or if any change in my employment that affects my earnings, and that failure to do so is an offence. I consent to the WorkCover Authority of NSW using the information collected in connection with my notification for the purposes of research about workers compensation, workplace injury management and occupational health and safety.

Signature: _____ Date: _____

Guardian (if under 18): _____

- Additional information and the completion of a Workers Compensation Claim Form may be required by WorkCover NSW
- A copy of this form should be retained for your records
- This form can be sent directly to WorkCover NSW, Locked Bag 2906, Lisarow NSW 2256 or via Fax to 02 9287 4828