WORKCOVER

WC301

Workers' Compensation and Injury Management Act 1981

Workers' Compensation and Injury Management Amendment Regulations (No. 2) 2016

Made by the Governor in Executive Council.

1. Citation

These regulations are the *Workers' Compensation and Injury Management Amendment Regulations (No. 2) 2016*.

2. Commencement

These regulations come into operation as follows —

(a) regulations 1 and 2 — on the day on which these regulations are published in the *Gazette*;

(b) the rest of the regulations — on 17 October 2016.

3. Regulations amended

These regulations amend the *Workers' Compensation and Injury Management Regulations 1982*.

4. Regulation 10 replaced

Delete regulation 10 and insert:

10. Worker not residing in State

(1) For the purposes of section 69, a worker must send to the employer or the employer's insurer a declaration by the worker and a medical practitioner in the form of Appendix I Form 6 —

(a) within 3 months after the date on which the worker is no longer residing in the State; and

(b) for each subsequent period during which the worker continues to receive weekly payments while not residing in the State, within 3 months after the date of the previous declaration by the worker and a medical practitioner.

(2) A declaration under subregulation (1) is taken to have been sent to an employer or an employer's insurer at the time it was —

(a) delivered personally to the last known business address of the employer or the employer's insurer; or

(b) posted to the last known business address of the employer or the employer's insurer; or

(c) sent by electronic means to the last known email address or fax number of the employer or the employer's insurer.

(3) An employer or an employer's insurer who disputes the identity or entitlement, or both, of a worker may apply —

(a) under section 182E of the Act for resolution of the dispute by conciliation; and

(b) under section 182ZT of the Act for determination of the dispute by arbitration, if the dispute is not resolved by conciliation.

5. Appendix I amended

In Appendix I delete Form 6 and insert:

Form 6

[r. 10(1)]

Workers' Compensation and Injury Management Act 1981
(Section 69)

DECLARATION OF WORKER NOT RESIDING IN W.A.

IF A WORKER RESIDES OUTSIDE THE STATE, PROOF OF THE WORKER'S IDENTITY AND CONTINUING INCAPACITY IS REQUIRED EVERY 3 MONTHS

PART 1 - WORKER'S DECLARATION

WORKER'S DETAILS			
First name		Last name	
Date of birth	/ /	Claim no.	
Phone		Email	
Address			
Date of injury			

DETAILS OF EMPLOYER or EMPLOYER'S INSURER

Name

Address

Email

DECLARATION BY WORKER

I have truthfully answered all the questions I have been asked and have fully cooperated to the best of my ability during the course of the medical examination by the medical practitioner named in PART 2 of this declaration.

Worker *(print name)*

Worker's signature

Date of declaration / /

Date sent to employer or employer's insurer / /

Sent by: Email ☐ Post ☐ Fax ☐

PART 2 - MEDICAL PRACTITIONER'S DECLARATION

MEDICAL ASSESSMENT

Date of this assessment / /

Date of injury / /

I declare that I have examined the person named in PART 1 of this declaration and I have confirmed that the person who I examined was that person through the sighting of an official document of the government of the country in which the person resides.

The document I used to confirm the identification of the person was *(for example a passport)*

MEDICAL MANAGEMENT

Clinical findings/ diagnosis

Medication

Imaging

Referral to specialist or hospital *(name)*

Approved health treatments *(specify type and number of sessions)*

WORK CAPACITY

Worker's usual duties

I find this worker to have:

☐ **full capacity for work from** / / ☐ but requires further treatment

☐ **some capacity for work from** / / to / / performing:

☐ pre-injury duties ☐ modified or alternative duties ☐ workplace modifications

☐ pre-injury hours ☐ modified hours of hours/day days/week

☐ **no capacity for any work from** / / to / /

Specify any work restrictions below. Where there is no capacity for work, please provide clinical reasoning.

MEDICAL PRACTITIONER'S DETAILS

Name

Medical registration number/country

Address

Medical specialty

Phone

Signature

Email

Date / /

(Practice stamp - optional)

R. KENNEDY, Clerk of the Executive Council.