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**WORKCOVER**

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WC301\*

Workers' Compensation and Injury Management Act 1981

**Workers' Compensation and Injury  
Management Amendment Regulations  
(No. 2) 2012**

Made by the Governor in Executive Council.

**1. Citation**

These regulations are the *Workers' Compensation and Injury Management Amendment Regulations (No. 2) 2012*.

**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 the day after that day.

**3. Regulations amended**

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

**4. Regulation 17AAA inserted**

After regulation 17 insert:

**17AAA. Variation of Amount C (clause 11(2))**

For the purposes of the definition of *Amount C* paragraph (b) in the Act Schedule 1 clause 11(2), the amount is obtained by multiplying by 2 the average of the amounts that the Australian Bureau of Statistics published as the all employees average weekly total earnings in Western Australia for pay periods ending in the months of May and November preceding the financial year.

**5. Regulation 44B amended**

In regulation 44B(1) in the definition of *exercise physiologist* delete “the Australian Association for Exercise and Sports Science.” and insert:

Exercise and Sports Science Australia.

6. Appendix I amended

- (1) In Appendix I in Form 2D in the Declaration delete "history." and insert:

history. However, I do not authorise the release or testing of human tissue samples or human tissue material of any kind or for any purpose.

- (2) In Appendix I delete Form 6 and insert:

Form 6

[r. 10(1)]

Workers' Compensation and Injury Management Act 1981

(Section 69)

DECLARATIONS IN RESPECT OF WORKER NOT RESIDING IN W.A.

[ ] = tick where appropriate. \* = delete where appropriate]

To: (name and address of employer or employer's insurer) .....

Re: Claim Number .....

1. WORKER'S SECTION

1a. Worker's details

First name(s): ..... Surname: .....
Address: .....
Telephone: ..... Date of birth: ...../...../..... Occupation: .....
Date of injury:..... Nature of injury: .....

1b. Employer details

Name and address of worker's employer: .....

1c. Declaration by worker

I, .....
(full name of worker)

\*being duly sworn, say that/do solemnly and sincerely affirm that the above details about me are correct.

\*Sworn/affirmed at ..... )
in ..... (State or country) )
this day of ..... 20 ) )
Before me: .....

(a person having authority to administer an oath)

2. MEDICAL PRACTITIONER'S SECTION

2a. Fitness for work

On ...../...../20..... I examined the above person and am of the opinion that he/she is —

Fit

- Fit to return to pre-injury duties, no further treatment required
Fit to return to pre-injury duties, but requires further treatment
Fit for restricted return to work from ..... to .....
Restricted hours (please specify) .....
Restricted days (please specify) .....
Restricted duties

- Work restrictions:
  - No lifting anything heavier than ..... kg
  - Avoid repetitive bending / lifting
  - Avoid repetitive use of the affected body part .....
  - Avoid prolonged standing / walking / sitting
  - Keep injured area clean and dry
  - Other restrictions .....

**Unfit**

- Unfit totally for work for ..... days from ..... to ..... (inclusive)

**2b. Medical assessment**

Clinical findings / diagnosis (include possible complications, effect of prior injury or medial conditions)

.....  
.....

**2c. Medical management at this consultation**

- Medication: .....
- Approved allied health treatments: (specify type and include number of sessions recommended) .....
- Imaging: .....
- Referred to another hospital/specialist: (name) .....
- Other treatment: .....

**2d. Progress report** (clinical findings/diagnosis at this consultation and possible barriers to return to work)

.....  
.....

**2e. Declaration by medical practitioner**

I, .....  
 (full name of medical practitioner)

of .....  
 (address)

Postcode: .....

\*being duly sworn, say that/do solemnly and sincerely affirm that —

1. I am a duly qualified medical practitioner.
2. The above details are correct.

\*Sworn/affirmed at ..... )  
 in (State or country))  
 this day of 20 )  
 Before me: .....

(a person having authority to administer an oath)

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

(3) In Appendix I delete Forms 16 and 17 and insert:

**Form 16**

[r. 15]

*Workers' Compensation and Injury Management Act 1981*

**MONTHLY STATEMENT BY APPROVED INSURANCE OFFICES**

CONFIDENTIAL

(Section 171(1)(a))

**NEW/RENEWED POLICIES/COVER NOTES**

Name of approved insurance office .....

Address .....

Chief executive officer, WorkCover WA.

The following are the names, addresses and industries of each employer who has during the month of ..... 20..... effected or renewed a policy or contract of insurance with the above office against liability under the Act.

WorkCover no.	Policy/cover note no.	New (N) Renewal (R) Cover note (C)	Name	Address	Industry	Effective date	Expiry date

Position held by officer ..... Date .....

.....  
Signature of responsible officer

**Form 17**

[r. 15]

*Workers' Compensation and Injury Management Act 1981*

**MONTHLY STATEMENT BY APPROVED INSURANCE OFFICES**

CONFIDENTIAL

(Section 171(1)(b))

LAPSED POLICIES

Name of approved insurance office .....

Address: ..... Date approved .....

Chief executive officer, WorkCover WA.

The following are the names and addresses of each employer in respect to whom, during the month of ..... 20..... the above approved insurance office has, in its books, lapsed a policy of insurance under the Act: —

WorkCover No.	Policy no.	Name	Address	Reason

Position held by officer ..... Date .....

.....  
Signature of responsible officer

By Command of the Governor,

G. MOORE, Clerk of the Executive Council.