

WESTERN  
AUSTRALIAN  
GOVERNMENT  
**Gazette**

6145



PERTH, TUESDAY, 14 DECEMBER 1999 No. 234 SPECIAL

PUBLISHED BY AUTHORITY JOHN A. STRIJK, GOVERNMENT PRINTER AT 4.00 PM

WORKERS' COMPENSATION AND  
REHABILITATION ACT 1981

---

**WORKERS'  
COMPENSATION AND  
REHABILITATION  
AMENDMENT  
REGULATIONS (No. 11)  
1999**



## Workers' Compensation and Rehabilitation Act 1981

## Workers' Compensation and Rehabilitation Amendment Regulations (No. 11) 1999

Made by the Governor in Executive Council.

### 1. Citation

These regulations may be cited as the *Workers' Compensation and Rehabilitation Amendment Regulations (No. 11) 1999*.

### 2. The regulations amended

The amendments in these regulations are to the *Workers' Compensation and Rehabilitation Regulations 1982\**.

[\* Reprinted as at 14 February 1995.

*For amendments to 7 December 1999 see 1998 Index to Legislation of Western Australia, Table 4, p. 354, and Gazette 13 and 16 April, 22 June and 15 October 1999.]*

### 3. Regulation 19J amended

Regulation 19J(1) is repealed and the following subregulation is inserted instead —

“

- (1) A referral under section 93D(5) of the Act —
  - (a) is to be made in the form of Form 22 in Appendix I; and
  - (b) is to nominate in the Form 22 one, and only one, relevant level of disability in respect of which the referral is made.

”.

### 4. Regulation 19M replaced

Regulation 19M is repealed and the following regulation is inserted instead —

“

#### 19M. Election to retain right to seek common law damages

- (1) An election under section 93E(3)(b) of the Act —
  - (a) is to be made in the form of Form 25 in Appendix I (the “**election form**”) and lodged with the Director; and

- (b) cannot be made unless —
  - (i) it is agreed that the degree of disability is not less than 16%; or
  - (ii) it is determined that the degree of disability is not less than 16%.
- (2) If it is agreed that the degree of disability is not less than 16% the election form is to be accompanied by Form 24 in Appendix I unless an agreement as to the degree of disability for the purposes of section 93E(3)(a), (4) or (9) of the Act was recorded under regulation 19K before the lodgment of the election form.
- (3) If it is determined that the degree of disability is not less than 16% the election form is to be accompanied by evidence of the determination unless a determination of a dispute as to the degree of disability was recorded under regulation 19L before the lodgment of the election form.
- (4) Subject to subregulation (5), on the day on which the Director receives the election form the Director is to —
  - (a) record —
    - (i) under regulation 19K(2)(a) the agreement (if any) accompanying the election form; or
    - (ii) under regulation 19L(2)(a) the determination (if any) accompanying the election form;
  - (b) register the election in a register kept for that purpose; and
  - (c) complete the relevant section of the election form and give a copy of it to the worker and the employer.
- (5) The Director may decline to register an election if the Director is satisfied that the worker does not fully understand the consequences of the registration of the election.
- (6) This regulation applies to an election under section 93E(3)(b) of the Act that is commenced on or after the day on which the *Workers' Compensation and Rehabilitation Amendment Regulations (No. 11) 1999* come into operation.

**5. Regulation 19N replaced**

Regulation 19N is repealed and the following regulation is inserted instead —

“

**19N. Extension of time to make election under s. 93E(3)(b)**

- (1) In this regulation —  
“**extension period**” means the period of time that ends 6 months after the termination day;  
“**termination day**” has the meaning that it has in section 93E of the Act.
- (2) For the purposes of section 93E(7) of the Act, the circumstances in which the Director may extend the period of time within which an election can be made under section 93E(3)(b) of the Act are if the Director is satisfied that —
  - (a) the worker will require major surgery in respect of the disability in the extension period;
  - (b) medical evidence that the worker will require major surgery in respect of the disability in the extension period has not been obtained from a medical practitioner who is a specialist in a relevant field of medicine despite all reasonably practicable steps having been taken by or on behalf of the worker to obtain that evidence; or
  - (c) a medical panel under section 36 of the Act has determined that the worker’s disability is of a kind mentioned in section 33 or 34 of the Act.
- (3) An application for an extension of time under subregulation (2)(a) is to be —
  - (a) made in the form of Form 26 in Appendix I;
  - (b) accompanied by medical evidence from a medical practitioner who is a specialist in a relevant field of medicine; and
  - (c) lodged with the Director at least 21 days before the termination day.
- (4) An application for an extension of time under subregulation (2)(b) is to be —
  - (a) made in the form of Form 27 in Appendix I;
  - (b) accompanied by such evidence, in addition to that provided in the Form 27, as may be requested by the Director about —
    - (i) the requirement for the worker to have the surgery mentioned in subregulation (2)(b); or

- (ii) the action taken by or on behalf of the worker to obtain the medical evidence mentioned in subregulation (2)(b);
  - and
  - (c) lodged with the Director at least 21 days before the termination day.
- (5) An application for an extension of time under subregulation (2)(c) is to be —
  - (a) made in the form of Form 26 in Appendix I;
  - (b) accompanied by evidence of the medical panel's determination; and
  - (c) lodged with the Director at least 21 days before the termination day.
- (6) Within 14 days of receiving the application the Director is to —
  - (a) decide whether to extend the period within which the election can be made;
  - (b) set the extension period in accordance with section 93E(7); and
  - (b) complete the relevant section of the application form and give a copy of it to the worker and the employer.
- (7) This regulation applies to an application for an extension under section 93E(7) of the Act of the period within which an election may be made that is lodged with the Director on or after the day on which the *Workers' Compensation and Rehabilitation Amendment Regulations (No. 11) 1999* come into operation.

”.

## 6. Regulation 19P inserted

After regulation 19O the following regulation is inserted in Part 3A —

“

### **19P. Notification to workers about elections as to common law damages**

- (1) The employer of a worker who has an unfinalized claim for compensation under the Act is to give the worker written notice of —
  - (a) the requirement under section 93E(3)(b) of the Act for the worker to elect to retain the right to seek damages; and
  - (b) the date by which the election is to be made.

- (2) The employer is to give the notice mentioned in subregulation (1) —
  - (a) if a dispute resolution body orders that weekly payments of compensation are to commence, within 7 days of the day of the order; or
  - (b) in any other case, 3 and 5 months from the day on which weekly payments commenced.

”.

**7. Appendix I amended**

- (1) Forms 3A and 4 in Appendix I are deleted and the following forms are inserted instead —

“

Form 3A

[r. 6B]

*Workers’ Compensation and Rehabilitation Act 1981*

[section 57A(3)(a)]

**Insurer’s Notice that Liability is Accepted**

To:

1. ....  
 [name and address of worker to whom the claim relates]

2. ....  
 [name and address of employer]

From: .....  
 [name and address of insurer]

\* Claim number:.....

Date of accident: .....

Nature of incapacity: .....

Date claim made by employer: .....

In respect of the above claim you are notified that liability is accepted in respect of the weekly payments claimed by the worker.

Date on which weekly payments are proposed to commence:.....

[Insurer to liaise with employer to ascertain the commencement date]

Signed on behalf of the insurer: .....

Date: .....

\* Please provide this claim number to your general practitioner at your next appointment in relation to this claim

Form 4

Workers' Compensation and Rehabilitation Act 1981

[section 61(1)]

Final Medical Certificate

Claim No. (if known)

To (name and address of worker's employer)

.....

WORKER'S DETAILS

First name(s): ..... Surname: .....
Address: .....
Telephone: .....
Date and place of occurrence of disability: .... / .... / .....

MEDICAL ASSESSMENT

Having examined the worker, it is my opinion that as from ..... / ..... / .....
[ ] the worker has total capacity for work.
[ ] the worker has partial capacity for work.
[ ] the worker's incapacity is no longer a result of the disability.

It is also my opinion that as from ..... / ..... / ..... the worker is
[ ] fit.
[ ] fit for alternative duties with the following limitations:
.....
.....
.....

Grounds for the opinion in medical assessment
.....
.....
.....
.....

MEDICAL PRACTITIONER'S DETAILS

Name: ..... Registration No.: .....
Address: .....
Telephone: .....
Fax: .....

Signature: ..... Time & Date of examination: .....

For workers' compensation information or assistance contact
WorkCover WA's Infoline: 08 9388 5555 Country callers: 1 800 670 055

”



- (2) Forms 22, 23, 24, 25, 26 and 27 in Appendix I are deleted and the following forms are inserted instead —

“

## Form 22

*Workers' Compensation and Rehabilitation Act 1981***Referral of Question of Degree of Disability**

[r. 19J(1)]

**Worker's details**

Surname		Other names
<input type="text"/>		<input type="text"/>
Date of birth	Sex	Occupation
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address		
<input type="text"/>		
Postcode		
<input type="text"/>		
Telephone no.		
<input type="text"/>		

**Employer's details**

Name	
<input type="text"/>	
Address	
<input type="text"/>	
Postcode	
<input type="text"/>	
Telephone no.	WorkCover no. (if known)
<input type="text"/>	<input type="text"/>
Contact person	
<input type="text"/>	
Title	Telephone no.
<input type="text"/>	<input type="text"/>

**Insurer's details**

Name	
<input type="text"/>	
Address	
<input type="text"/>	
Postcode	
<input type="text"/>	
Date weekly payments commenced (if applicable).	Claim no. (if known)
<input type="text"/>	<input type="text"/>
Contact person	
<input type="text"/>	
Telephone no.	
<input type="text"/>	

**Disability details**

Description of disability

--

Date disability occurred

--

Date weekly payments commenced

--

Degree of disability as assessed  
by medical practitioner

--

Relevant level of disability (see s. 93E(3) of the Act)

Nominate **only one** relevant level of disability.

- not less than 30%
- not less than 16%

Tick if the worker and the employer cannot agree on whether the degree of  
disability is not less than the relevant level

The action taken by or on behalf of the worker to obtain the employer's agreement


**Signature  
of worker**

Date

/ /
-----

**Lodging this form**

This form should be lodged with —

Director, Conciliation and Review Directorate  
WorkCover WA  
Perth, Western Australia

You must also give to the Director medical evidence from a medical practitioner indicating that, in his or her opinion, your degree of disability is not less than the relevant level.

## Form 23

*Workers' Compensation and Rehabilitation Act 1981*  
**Notice of Referral of Question of Degree of Disability**

[r. 19J(2), (3)]

**Worker's details**

Surname

--

Other names

--

Address

Postcode

Telephone no.

--

Occupation

--

**Employer's details**

Name

Address

Postcode

Telephone no.  WorkCover no. (if known)

**Disability details**

Description of disability

Date disability occurred

Degree of disability as assessed by medical practitioner

Relevant level of disability  
 not less than 30%  
 not less than 16%

**Question referred**

The question of whether the worker's degree of disability is or is not less than the relevant level has been referred to the Director, Conciliation and Review Directorate, for consideration.

**Medical evidence**

Accompanying this notice is a copy of the medical evidence provided by the worker which indicates that in the opinion of the worker's medical practitioner the worker's degree of disability is not less than the relevant level.

**Objection**

If you (the employer) consider the worker's degree of disability is less than the relevant level, you should complete the bottom section of this form and return it to the Director within 21 days of receiving this notice.

**If you do not notify the Director within 21 days you will be taken to have agreed that the worker's degree of disability is not less than the relevant level**

**Signature of Director** \_\_\_\_\_ Date

**Employer's objection**

Employer's assessment of degree of disability	<input type="text"/>	<input type="text"/>
<b>Signature of employer</b> _____	Date	<input type="text"/>

## Form 24

*Workers' Compensation and Rehabilitation Act 1981***Degree of Disability Agreement**

[r. 19K(1), (2)]

**Worker's details**

Surname	Other names
<input type="text"/>	<input type="text"/>
Address	
<input type="text"/>	
Postcode	
<input type="text"/>	Occupation
<input type="text"/>	<input type="text"/>

**Employer's details**

Name	<input type="text"/>
Address	
<input type="text"/>	
Postcode	
Telephone no.	WorkCover no. (if known)
<input type="text"/>	<input type="text"/>

**Insurer's details**

Name	<input type="text"/>
Address	
<input type="text"/>	
Postcode	
Date weekly payments commenced (if applicable).	Claim no. (if known)
<input type="text"/>	<input type="text"/>
Contact person	<input type="text"/>
<input type="text"/>	
Telephone no.	<input type="text"/>

**Disability details**

Description of Disability
<input type="text"/>
Date disability occurred
<input type="text"/>

**Agreement**

Agreed degree of disability  
(insert actual figure e.g. 22%)

%

Agreed degree of disability is —

- not less than 30%
- not less than 16%

<p><b>Signature of Worker</b> _____</p>	<p>Date</p>	<p><input type="text"/> / <input type="text"/> / <input type="text"/></p>
<p><b>Signature of witness</b> _____</p>	<p>Name of witness</p>	<p>_____</p>

<p><b>Signature of Employer</b> _____</p>	<p>Date</p>	<p><input type="text"/> / <input type="text"/> / <input type="text"/></p>
<p><b>Signature of witness</b> _____</p>	<p>Name of witness</p>	<p>_____</p>

**Recording of agreement**

<p>Date of recording</p> <p><input type="text"/></p>	<p>Record no.</p> <p><input type="text"/></p>
--	---

<p><b>Signature of Director</b> _____</p>	<p>Date</p>	<p><input type="text"/> / <input type="text"/> / <input type="text"/></p>
---	-------------	---

Form 25

*Workers' Compensation and Rehabilitation Act 1981*

**Election to Retain Right to Seek Damages**

[r. 19M(1)]

**Worker's details**

<p>Surname</p> <p><input type="text"/></p>	<p>Other names</p> <p><input type="text"/></p>	
<p>Date of birth</p> <p><input type="text"/></p>	<p>Sex</p> <p><input type="text"/></p>	<p>Occupation</p> <p><input type="text"/></p>
<p>Address</p> <p><input type="text"/></p>		
<p>Postcode</p> <p><input type="text"/></p>		
<p>Telephone no.</p> <p><input type="text"/></p>		

**Employer's details**

Name	
<input type="text"/>	
Address	
<input type="text"/>	
Postcode	
Telephone no.	WorkCover no. (if known)
<input type="text"/>	<input type="text"/>
Contact person	
<input type="text"/>	
Title	Telephone no.
<input type="text"/>	<input type="text"/>

**Insurer's details**

Name	
<input type="text"/>	
Address	
<input type="text"/>	
Postcode	
Date weekly payments commenced	Claim no. (if known)
<input type="text"/>	<input type="text"/>
Contact person	
<input type="text"/>	
Telephone no.	
<input type="text"/>	

**Disability details**

Description of disability
<input type="text"/>

Date disability occurred
<input type="text"/>

Has a Degree of Disability Agreement (Form 24) already been recorded by the Director?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
If yes:	.....date when recorded	
	.....record number	
Degree of disability as agreed.....%		

Has the determination of a dispute as to the degree of disability already been recorded under reg. 19L by the Director?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
If yes:	.....date when recorded	
	.....record number	
Degree of disability as determined.....%		

<b>Signature of Worker</b> _____	Date	/ /
----------------------------------	------	-----

**Warning**

The registration of this election will, in most cases, prevent you from continuing to receive statutory benefits under the *Workers' Compensation and Rehabilitation Act 1981*.

**You should seek appropriate independent advice before lodging this form.**

**Registration of election**

Date of registration	Registration no.

<b>Signature of Director</b> _____	Date	/ /
------------------------------------	------	-----

## Form 26

*Workers' Compensation and Rehabilitation Act 1981***Application for Extension of Time to Make Election (medical evidence available)**

[r. 19N(3)(a) and (5)(a)]

**Worker's details**

Surname	Other names	
Date of birth	Sex	Occupation
Address		
Postcode		
Telephone no.		

**Employer's details**

Name	
Address	
Postcode	
Telephone no.	WorkCover no. (if known)

Contact person

--

Title

--

Telephone no.

--

**Insurer's details**

Name

--

Address

--

Postcode

Date weekly payments commenced

--

Claim no. (if known)

--

Contact person

--

Telephone no.

--

**Disability details**

Description of disability

--

Degree of disability

Date disability occurred

--

(as assessed by worker's medical specialist)

%
---

**Extension of time sought**

The application for extension of time is made under —

 regulation 19N(2)(a)

OR

 regulation 19N(2)(c)

Extension sought until

--

**Signature****of Worker**

Date

/ /
-----

**Lodging this form**

This form should be lodged with —

Director, Conciliation and Review Directorate

WorkCover WA

Perth, Western Australia

If applying under regulation 19N(2)(a) you must also give to the Director medical evidence from a medical practitioner who is a specialist in a relevant field of medicine indicating that you will require major surgery in the extension period (see regulation 19N(1)).

If applying under regulation 19N(2)(c) you must give the Director evidence of the medical panel's determination.



**Granting of extension**

An extension of time to make an election under section 93E(3)(b) of the Act —	
<input type="checkbox"/> is granted until    /    /	OR <input type="checkbox"/> is not granted

The extension of time is granted under —	
<input type="checkbox"/> regulation 19N(2)(a)	OR <input type="checkbox"/> regulation 19N(2)(c)

<b>Signature of Director</b> _____	Date	/ /

## Form 27

*Workers' Compensation and Rehabilitation Act 1981***Application for Extension of Time to Make Election (medical evidence not yet available)**

[r. 19N(4)(a)]

**Worker's details**

Surname		Other names	
Date of birth	Sex	Occupation	
Address			
Postcode			
Telephone no.			

**Employer's details**

Name	
Address	
Postcode	
Telephone no.	WorkCover no. (if known)
Contact person	
Title	Telephone no.

**Insurer's details**

Name

Address

Postcode
----------

Date weekly payments commenced

Claim no. (if known)

Contact person

Telephone no.

**Disability details**

Description of disability

Date disability occurred

**Extension of time sought**

Extension sought until

State grounds on which the worker submits that he or she will require major surgery in respect of the disability in the extension period (see regulation 19N(1))


State the action that has been taken by or on behalf of the worker to obtain medical evidence from a medical practitioner who is a specialist in a relevant field of medicine that the worker will require major surgery in respect of the disability in the extension period


(attach separate sheet if insufficient room)

**Signature  
of Worker**

\_\_\_\_\_ Date

**Lodging this form**

This form should be lodged with —

Director, Conciliation and Review Directorate

WorkCover WA

Perth, Western Australia

You must also give to the Director any further evidence that the Director may request in relation to this application.

**Granting of extension**

An extension of time to make an election under section 93E(3)(b) of the Act —		
<input type="checkbox"/>	is granted until	/ /
	OR	<input type="checkbox"/>
		is not granted

<b>Signature of Director</b>	_____	Date	<table border="1"> <tr> <td>/</td> <td>/</td> </tr> </table>	/	/
				/	/

”.

By Command of the Governor,

M. C. WAUCHOPE, Clerk of the Executive Council.



1 9 9 9 0 0 2 3 4 6 6