

WORKERS COMPENSATION AND REHABILITATION**WC301 WORKERS' COMPENSATION AND REHABILITATION ACT 1981
WORKERS' COMPENSATION AND REHABILITATION AMENDMENT
REGULATIONS (NO. 4) 1993**

Made by His Excellency the Governor in Executive Council.

Citation

1. These regulations may be cited as the *Workers' Compensation and Rehabilitation Amendment Regulations (No. 4) 1993*.

Commencement

2. These regulations come into operation on the day on which section 25 of the *Workers' Compensation and Rehabilitation Amendment Act 1993* comes into operation.

Principal regulations

3. In these regulations the *Workers' Compensation and Rehabilitation Regulations 1982** are referred to as the principal regulations.

[* Reprinted as at 30 April 1992.

For amendments to 20 December 1993 see 1992 Index to Legislation of Western Australia, Table 4, p. 324, and Gazette of 5 February, 17 September and 29 October 1993.]

Regulation 3 inserted

4. Before regulation 4 of the principal regulations the following regulation is inserted —

"

AMA Guides

3. The first edition is prescribed for the purposes of the definition of "AMA Guides" in section 93A of the Act.

"

Regulation 8 amended

5. Regulation 8 of the principal regulations is amended in subregulation (1) —

- (a) by deleting "shall be required, after" and substituting the following —

"

shall not be required under section 64 or 65 of the Act, before

";

and

- (b) by deleting "not more frequently" and substituting the following —

" , nor to do so more frequently ".

Regulation 10 amended

6. Regulation 10 of the principal regulations is amended by repealing subregulation (1) and substituting the following subregulation —

"

(1) For the purposes of section 69 of the Act, a worker shall prove his identity and the continuance of the incapacity in respect of which a weekly payment is payable, by delivering to the employer or the employer's insurer, at intervals of 3 months, a declaration by the worker and by a medical practitioner in the form of or to the effect of Form 6.

"

Regulations 10A and 10B inserted

7. After regulation 10 of the principal regulations the following regulations are inserted —

"

Request for reference to medical assessment panel

10A. A worker or employer requesting a reference to a medical assessment panel under section 70 (1) of the Act is to —

- (a) request the reference in the form of Form 20 in Appendix I, modified as the case requires; and
- (b) pay to the Executive Director a fee of \$50.

Proceedings before medical assessment panel

10B. (1) When referring a question to a medical assessment panel the Director is to provide the panel with any medical certificates or reports or other documents that it may have that are relevant to the question to be determined by the panel.

(2) A medical assessment panel may determine the times and places at which a worker is to attend before it.

(3) The form in which a medical assessment panel may require a worker to attend before it is the form set out in Form 13.

"

Regulation 19C amended

8. Regulation 19C (4) of the principal regulations is amended —

- (a) by deleting "subsection (5)" and substituting the following —
" subregulation (5) "; and
- (b) in paragraph (b), by deleting "subregulation (4) (a) (i)" and substituting the following —
" paragraph (a) (i) ".

Regulation 19G amended

9. Regulation 19G of the principal regulations is amended —

- (a) by inserting before "panel" the following —
" assessment "; and
- (b) in paragraph (b), by deleting "Executive".

Appendix I amended

10. Appendix I to the principal regulations is amended —

- (a) in Form 2, by deleting items 1 to 5 under the heading "DETERMINATION" and substituting the following —
"
1. Is, or was, the worker suffering from pneumoconiosis, mesothelioma or lung cancer?
2. If so, is, or was, the worker thereby disabled from earning full wages?

3. To what extent if any does, or did —

- (i) pneumoconiosis;
- (ii) mesothelioma;
- (iii) lung cancer,

cause impairment of his ability to undertake physical effort?

4. What other, if any, disease or physical condition is, or was, contributing to the worker's disablement or death and to what extent?

5. Is, or was, the worker fit for work? If so, at what level — light, moderate, or heavy?

(b) in Form 2B, by deleting

" — travelling between home and work? 4";

(c) by deleting Form 3 and substituting the following Form —

"

FORM 3

Workers' Compensation and Rehabilitation Act 1981

[sections 57A (1) (b) and 57B (1) (b)]

FIRST MEDICAL CERTIFICATE

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

A. WORKER'S DETAILS

To: (Name and address of worker's employer)

Employer's contact person: (Supervisor) Phone:

Worker's name in full:

Address: Phone:

Occupation: Date of birth: / /19

Date and place of disability: / /19

Worker's description of how the disability occurred:

.....

Worker's description of the injury or disease:

B. MEDICAL ASSESSMENT OF DISABILITY

(see definition of "disability" on reverse)

1. Date of 1st attendance: / /19 at: AM/PM

2. Diagnosis (include location of injury on the body, likely complications, effect of any prior injury or medical condition):

.....

Is this diagnosis provisional? Yes No

3. It is my opinion that as from the date of this certificate the worker is:

- (a) Fit.
- (b) Fit BUT requires further treatment.
- (c) Unfit for normal duties *for weeks days/
*until / /19... BUT may be fit for alternative duties. (See
C.1 below)
- (d) Totally unfit for work *for weeks days/
*until / /19 ...

4. Management and/or treatment:
- (a) Home based (e) Imaging
 (b) At surgery (f) Physiotherapy
 (c) Hospital (g) Other (please specify)
 (d) Referred to specialist, name:

C. VOCATIONAL REHABILITATION

(see definition of "vocational rehabilitation" on reverse)

1. If alternative duties are available, I am prepared to review the worker's ability to carry out those duties.
2. Is vocational rehabilitation likely to be necessary?
 Yes No Subject to review.
3. If referred to a rehabilitation provider, please specify:

This certificate has been compiled on the basis of the worker's statements to me and my physical examination of the worker. In my opinion the above diagnosis *does/does not correlate with the disability described to me by the worker.

I *will/will not review the worker.

Next appointment: / /19 at: AM/PM

Should you wish to discuss the management and/or treatment of the worker, please contact me.

Name and address of registered medical practitioner: (please print or use stamp)

..... Phone:
 Signature: Date: / /19

WORKER'S AUTHORITY (to be signed at the option of the worker)

I hereby authorize any doctor who treats me (whether named in this certificate or not) to give to my employer, or his or her insurer, any information in relation to my claim for worker's compensation which he or she may have acquired with regard to me.

Signature: Date: / /19

REVERSE OF FORM 3

Workers' Compensation and Rehabilitation Act 1981

Extracts from section 5 of the Act:

" [Here the form is to set out the definition of "disability" that is in the "Act.]

[Reference should also be made to sections 5 (4) and (5) of the Act.]

" [Here the form is to set out the definition of "vocational rehabilitation" that is in the Act.] "

";

- (d) by deleting Form 4 and substituting the following Form —
“

FORM 4
Workers' Compensation and Rehabilitation Act 1981
[section 61 (1)]

FINAL MEDICAL CERTIFICATE

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

A. WORKER'S DETAILS

To: (Name and address of worker's employer)
.....

Worker's name in full:

Address: Phone:

Date and place of occurrence of disability: / /19

B. MEDICAL ASSESSMENT OF DISABILITY

(see definition of "disability" on reverse)

1. Date of this attendance: / /19 at: AM/PM
2. Having examined the worker, it is my opinion that as from / /19 :
 - (a) the worker has wholly recovered from the effects of the disability; OR
 - (b) the worker has partially recovered from the effects of the disability; OR
 - (c) the worker's incapacity is no longer a result of the disability.
3. It is also my opinion that as from / /19 the worker is:
 - (a) Fit.
 - (b) Fit BUT requires further treatment.
 - (c) Unfit for normal duties *for weeks days/
*until / /19... BUT may be fit for alternative duties with the following limitations:
 - (d) Totally unfit for work *for weeks days/
*until / /19...
4. Grounds for the opinions in item 2 above:
(include clinical findings and diagnosis if necessary)
.....
.....
.....
.....

Name and address of registered medical practitioner: (please print or use stamp)

..... Phone:
Signature: Date: / /19

REVERSE OF FORM 4

Workers' Compensation and Rehabilitation Act 1981

Extracts from section 5 of the Act:

“ [Here the form is to set out the definition of "disability" that is in the „
Act.]

[Reference should also be made to sections 5 (4) and (5) of the Act.]

”;

(e) by deleting Form 6 and substituting the following Form —

“

FORM 6

Workers' Compensation and Rehabilitation 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)

A. WORKER'S SECTION

I,
 (full name of worker)
 of
 (residential address)

Occupation: Postcode: Date of birth: / /19

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

1. The above details about me are correct.
2. I reside at the above address.
3. On / /19 I suffered a disability when employed by
 (name and address of employer)

*Sworn/affirmed at
 in (State or country)
 this day of 19)

Before me:
 (a person having authority to administer an oath)

B. DOCTOR'S SECTION

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. On / /19 ... I examined the above person and am of the opinion that he/she is —
 (a) Fit.
 (b) Fit BUT requires further treatment.
 (c) Unfit for normal duties *for weeks days/
 *until / /19... BUT may be fit for alternative duties.
 (See C.1 below)
 (d) Totally unfit for work *for weeks days/
 *until / /19 ...

*Sworn/affirmed at
 in (State or country)
 this day of 19)

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**

";

- (f) by inserting before Form 14 the following Form —

"

Form 13 [Reg. 10B (3)]

Workers' Compensation and Rehabilitation Act 1981

**REQUIREMENT TO ATTEND BEFORE A
MEDICAL ASSESSMENT PANEL**

You are required to attend before a medical assessment panel at

. at the hour of

on the

day of 19

* and at that time to produce to the panel

. (specified documents)

* *delete if inapplicable*

Dated

. **CHAIRMAN**
Medical Assessment Panel

";

- (g) in Forms 14 and 15, by inserting after "mesothelioma" in each case the following —

" lung cancer ";

and

- (h) in Form 20 —

- (i) in the heading, by inserting before "PANEL" the following —

" ASSESSMENT ";

- (ii) by deleting "EXECUTIVE DIRECTOR" and substituting the following —

" DIRECTOR OF CONCILIATION AND
REVIEW ";

and

- (iii) by inserting before "panel" the following —

" assessment ".

By His Excellency's Command,

D. G. BLIGHT, Clerk of the Council.