WORKERS COMPENSATION AND REHABILITATION

WC301

WORKERS' COMPENSATION AND REHABILITATION ACT 1981
WORKERS' COMPENSATION AND ASSISTANCE AMENDMENT REGULATIONS (No. 2) 1991

Made by His Excellency the Governor in Executive Council.

Citation

1. These regulations may be cited as the *Workers' Compensation and Assistance Amendment Regulations (No. 2) 1991.*

Commencement

2. The regulations shall come into operation on the day on which the *Workers' Compensation and Assistance Amendment Act 1990* comes into operation.

Principal regulations

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

[**Published in the Gazette of 8 April 1982 at pp. 1229-50. For amendments to 19 February 1991, see Index to Legislation of Western Australia 1989, p. 403.*]

Regulation 1 amended

4. Regulation 1 of the principal regulations is amended by deleting "Assistance" and substituting the following—

" Rehabilitation ".

Regulation 6 repealed and regulations substituted

5. Regulation 6 of the principal regulations is repealed and the following regulations are substituted—

" **Form of notice of occurrence of disability**

6. Form 2A in Appendix I is the prescribed form under section 130 (1) (a) of the Act.

Form of medical certificate

6A. Form 3 in Appendix I is the prescribed form under sections 57A (1) (b) (i) and 57B (1) (b) (i) of the Act.

Form for insurer accepting liability

6B. Form 3A in Appendix I is the prescribed form under section 57A (3) (a) of the Act.

Form for insurer disputing liability

6C. Form 3B in Appendix I is the prescribed form under section 57A (3) (b) of the Act.

Form for insurer undecided on liability

6D. Form 3C in Appendix I is the prescribed form under section 57A (3) (c) of the Act.

Form for employer disputing liability

6E. Form 3D in Appendix I is the prescribed form under section 57B (2) (b) of the Act.

Form for employer undecided on liability

6F. Form 3E in Appendix I is the prescribed form under section 57B (2) (c) of the Act. ".

Regulation 12 repealed

6. Regulation 12 of the principal regulations is repealed.

Regulation 14 repealed and a regulation substituted

7. Regulation 14 of the principal regulations is repealed and the following regulation is substituted—

" **Particulars to be supplied about worker incapacitated for more than 4 weeks**

14. Under section 155 (2) of the Act the prescribed particulars are—

(a) the full name of the worker concerned;

(b) the number given by the insurer or self-insurer to the claim by the worker for compensation; and

(c) whether either paragraph (a) or paragraph (b) of that section applies to the worker. ".

Appendix I amended

8. Appendix I to the principal regulations is amended—

(a) by inserting after Form 2 the following form—

"

Form 2A (Reg 6)

WORKERS' COMPENSATION AND REHABILITATION ACT 1981

[section 130 (1)]

WORKER'S NOTICE OF OCCURRENCE OF DISABILITY

WORKER'S DETAILS

Surname: .....

Other names: .....

Address: .....

..... Postcode: .....

Phone No.: .....

Date of birth: ...../...../..... Age: ..... Male/Female

Occupation: .....

Main tasks or duties performed: .....

.....

Full time ☐ F

Part time ☐ P

At the time of the occurrence were you working as a:

—direct employee? ☐ 1

—working director? ☐ 2

—contractor? ☐ 3

—employee of contractor? ☐ 4

—sub-contractor? ☐ 5

—other? ☐ 6

If you have difficulty understanding English, what is your preferred language? .....

OCCURRENCE DETAILS

Day of occurrence: ..... Date: ...../...../..... Time: .....:..... am/pm.

At what address did the occurrence occur? .....

.....

Where did the occurrence occur? .....

.....

What were you doing at the time of the occurrence? .....

.....

Were you:

—on duty? ☐ 1

—on duty and in a road traffic accident? ☐ 2

—on a work break? ☐ 3

—travelling between home and work? ☐ 4

—doing something else, if so what? ☐ 5

.....

What actually happened and what caused the occurrence?

Include:

(i) what action was involved: .....

.....

(ii) what object/machine was involved: .....

.....

Describe:

(i) the most serious type(s) of injury or disease caused by the occurrence: .....

.....

(ii) bodily location of the injury or disease: .....

.....

OCCURRENCE REPORT

1. When did you have to stop working? Date: ...../...../.....
Time: ..... : ..... am/pm.

2. What were the normal working hours for that day?
Starting time: ..... : ..... am/pm. Finishing time: ..... : ..... am/pm.

3. When did you first report the occurrence? Date: ...../...../.....
Time: ..... : ..... am/pm.

4. to whom did you report the occurrence?
Name: .....
Title: .....

5. If the occurrence was not reported immediately, state the reason: .
.....

6. Name and address of witness(es) to the occurrence: .....
.....

MEDICAL ATTENTION/HISTORY—THIS OCCURRENCE

1. When did you first seek medical attention? Date: ...../...../.....
Time: .....:..... am/pm

2. If not immediately, state reason: .....
.....

3. Was the part of the body affected or injured by this occurrence healthy before the occurrence? Yes/No
If not, give details: .....
.....

MEDICAL HISTORY—SIMILAR OR RELATED PREVIOUS EVENTS

4. Is the present injury or disability totally attributable to this occurrence? Yes/No
If not, give details: .....
.....

5. Give details of any similar injury or disability prior to this occurrence: .....
.....

6. Name and address of usual medical practitioner and any person who has treated you for a similar disability:
.....
.....

OTHER OR PREVIOUS CLAIMS

1. Is compensation being claimed from any other source?
Yes/No If yes, from whom? .....

2. Give details of similar or related previous workers' compensation claims:
Name and address of employer: .....
Name of insurer (if known): .....
Nature of injury, disease or other claim: .....
.....

WORKER'S DECLARATION

I solemnly and sincerely declare that each and every answer above and the particulars contained herein or annexed hereto relating to myself and the occurrence are true both in substance and in fact to the best of my knowledge and belief.

I take notice that under section 59 (1) of the *Workers' Compensation and Rehabilitation Act 1981* I am required to notify my employer within 7 days should I commence work with another employer after making a claim, or while receiving weekly payments of workers' compensation.

Dated this ..... day of ..... 19.....
Signature of worker: .....
Signature of witness: .....

I hereby authorize any doctor to divulge to my employer, or his or her insurer, information in relation to my claim for workers' compensation which he or she may have acquired with regard to myself.

Dated this ..... day of ..... 19.....
Signature of worker: .....
Signature of witness: .....

NOTE: Failure to provide your signature on either of the above declarations may delay the finalisation of your claim.

EMPLOYER DETAILS (To be completed by employer)

Trading name of employer: .....
Address of worker's usual workplace or base: .....
.....
Major activity of workplace: .....
.....
Name of policy holder: .....
Postal address: .....
..... Postcode: .....
If a local government, name: .....
Insurance Co.: .....
Policy No.: .....

INSURER TO COMPLETE

Insurer's date stamp: ..... Claim No.: .....

Insurance Company—Please detach and forward the duplicate of this notice to the Workers' Compensation and Rehabilitation Commission.

(b) in Form 3 by deleting—

"WORKERS' COMPENSATION AND ASSISTANCE ACT 1981.

FIRST MEDICAL CERTIFICATE.

Medical Certificate Supporting Commencement of Weekly Payments in accordance with Section 58 (1) of the Act."

and substituting the following—

" WORKERS' COMPENSATION AND REHABILITATION ACT 1981

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

FIRST MEDICAL CERTIFICATE ";

(c) by inserting after Form 3 the following forms—

"

Form 3A (Reg 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.

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

Date: .....

Form 3B (Reg 6C)

WORKERS' COMPENSATION AND REHABILITATION ACT 1981

[section 57A (3) (b)]

INSURER'S NOTICE THAT LIABILITY IS DISPUTED

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 disputed in respect of:

* all the weekly payments claimed by the worker.

* the following weekly payments claimed by the worker.
[provide details]

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

Date: .....

[*delete if appropriate]

Form 3C (Reg 6D)

WORKERS' COMPENSATION AND REHABILITATION ACT 1981

[section 57A (3) (c)]

INSURER'S NOTICE WHERE NO DECISION ABOUT LIABILITY

To:

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

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

3. Registrar, Workers' Compensation Board.

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 a decision as to whether or not liability is to be accepted in respect of the weekly payments claimed by the worker is not able to be made within the time allowed by section 57A (3) of the Act.

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

Form 3D (Reg 6E)

WORKERS' COMPENSATION AND REHABILITATION ACT 1981

[section 57B (2) (b)]

UNINSURED OR SELF-INSURED EMPLOYER'S NOTICE THAT LIABILITY IS DISPUTED

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

From: .....
[name and address of uninsured or self-insured employer]
.....

Claim number: .....
Date of accident: .....
Nature of incapacity: .....
.....
Date claim made by worker: .....

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

Signed on behalf of the uninsured or self-insured employer: .....
Date: .....

Form 3E (Reg 6F)

WORKERS' COMPENSATION AND REHABILITATION ACT 1981

[section 57B (2) (c)]

UNINSURED OR SELF-INSURED EMPLOYER'S NOTICE WHERE NO DECISION ABOUT LIABILITY

To:

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

2. Registrar, Workers' Compensation Board.

From: .....
[name and address of uninsured or self-insured employer]
.....

Claim number: .....
Date of accident: .....
Nature of incapacity: .....
.....

Date claim made by worker: .....

In respect of the above claim you are notified that a decision as to whether or not liability to make the weekly payments claimed by the worker is not able to be made within the time allowed by section 57B (2) of the Act.

Signed on behalf of the uninsured or self-insured employer: .....
Date: .....

"; and

(d) by deleting Forms 7, 8, 9, 10, 11 and 13.

Consequential amendments

9. (1) Appendix I to the principal regulations is amended in Forms 1, 2, 4, 5 (other than in paragraph (5)), 6, 12, 14, 15, 16, 17, 18, 19A, 19B, 20 and 21 by deleting "Assistance" wherever it occurs and substituting the following—

" Rehabilitation ".

(2) Form 5 in Appendix I of the principal regulations is amended in paragraph (5) by deleting "Workers' Assistance Commission" and substituting the following—

" Workers' Compensation and Rehabilitation Commission ".

By His Excellency's Command,

L. AULD, Clerk of the Council.