WORKERS COMPENSATION AND REHABILITATION

WC301

WORKERS' COMPENSATION AND REHABILITATION ACT 1981
WORKERS COMPENSATION AND REHABILITATION AMENDMENT REGULATIONS (No. 3) 1991

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. 3) 1991.*

Commencement

2. These regulations shall come into operation on 1 July 1991.

Principal regulations

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

[**Published in the Gazette of 8 April 1982, pp. 1229-50. For amendments to 10 June 1991, see 1990 Index to Legislation of Western Australia, p. 422-3 and Gazettes of 26 January 1991 and 8 March 1991.*]

Regulation 6 repealed and regulations substituted

4. Regulation 6 of the principal regulations is repealed and the following regulations are substituted—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 claim for compensation

6AA. Form 2B in Appendix I is the prescribed form under section 130 (1) (b) of the Act. ".

Regulation 16 amended

5. Regulation 16 of the principal regulations is amended by deleting "$1 100" and substituting the following—

" $3 500 ".

Regulation 17A amended

6. Regulation 17A of the principal regulations is amended—

(a) in paragraph (a) by deleting "$70" and substituting the following—

" $74 "; and

(b) in paragraph (b) by deleting "$40" and substituting the following—

" $42 ".

Form 2A deleted and a form substituted

7. Appendix I to the principal regulations is amended by deleting Form 2A and substituting the following form—

"

FORM 2A

(Reg. 6)

WORKERS' COMPENSATION AND REHABILITATION ACT 1981

[section 130(1)(a)]

NOTICE OF OCCURRENCE OF DISABILITY

Name of worker: .....

Home address of worker: .....

.....

Nature and cause of disability: .....

.....

.....

Date disability occurred: ...../...../.....

Workplace where disability occurred: .....

.....

.....

Signature of worker or person acting on the worker's behalf:

.....

Date of notice: ...../...../.....

THIS NOTICE OR THE INFORMATION CONTAINED IN THIS NOTICE IS TO BE GIVEN TO THE EMPLOYER AS SOON AS PRACTICABLE AFTER THE OCCURRENCE OF THE DISABILITY

".

Form 2B inserted

8. Appendix I to the principal regulations is amended by inserting after Form 2A the following form—

"

FORM 2B

(Reg. 6AA)

WORKERS' COMPENSATION AND REHABILITATION ACT 1981

[section 130(1)(b)]

WORKER'S CLAIM FOR COMPENSATION

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	At the time of the occurrence	
Part time ☐ P	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, is 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. ".

Forms 16 and 17 amended

9. Appendix I to the principal regulations is amended in Forms 16 and 17 by deleting "The Manager, Workers' Rehabilitation Commission, PERTH." and substitute the following—

" Executive Director, Workers' Compensation and Rehabilitation Commission. ".

By His Excellency's Command,

L. M. AULD, Clerk of the Council.