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WORKERS' COMPENSATION AND REHABILITATION ACT 1981

WORKERS' COMPENSATION AND REHABILITATION AMENDMENT REGULATIONS 1999

Workers' Compensation and Rehabilitation Amendment Regulations 1999

Made by the Governor in Executive Council.

1. Citation

These regulations may be cited as the *Workers' Compensation and Rehabilitation Amendment Regulations 1999.*

2. Commencement

These regulations come into operation on 3 May 1999.

3. 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 11 March 1999 see 1997 Index to Legislation of Western Australia, Table 4, p. 312, and Gazette 12 June 1998.]

4. Regulation 6AA amended

(1) Regulation 6AA is amended by inserting before "Form 2B or" the subregulation designation "(1)".

(2) At the end of regulation 6AA the following subregulation is inserted —

"

(2) In addition to the details prescribed in Form 2B as being necessary to make a valid claim for compensation under section 84I(1)(b) —

(a) the "Injured worker's declaration" and the "Consent authority"; and

(b) the tear-off attachments headed "DETAILS TO BE PROVIDED TO MEDICAL PRACTITIONER" and "INFORMATION TO BE PROVIDED TO THE INJURED WORKER",

are prescribed under section 176(1)(a) as expedient for the purposes of the Act, and are to be completed and given to the appropriate parties accordingly.

".

5. Regulation 6A amended

(1) Regulation 6A is amended by inserting before "Form 3 in" the subregulation designation "(1)".

(2) At the end of regulation 6A the following subregulation is inserted —

"

(2) In addition to the details prescribed in Form 3 as being necessary to make a valid claim for compensation under sections 57A and 57B, the "Consent Authority" is prescribed under section 176(1)(a) as expedient for the purposes of the Act, and is to be completed accordingly.

".

6. Regulation 7 amended

Regulation 7(1) is amended by deleting the full stop after "Appendix I" and inserting instead —

"

, or in the form of Form 3 in Appendix I if that form has been marked to indicate that it is to be regarded as both a first and final medical certificate.

".

7. Regulation 8 replaced

Regulation 8 is repealed and the following regulation is inserted instead —

"

8. Frequency and time of medical examinations (s. 66)

(1) A worker who receives a First Medical Certificate (Form 3) under the Act which nominates a medical review of the worker within a period of 14 days from the date the certificate is issued cannot be required, under section 64 or 65 of the Act, to submit himself for examination by a medical practitioner provided by the employer before a period of one month has elapsed from the date the certificate is issued.

(2) A worker who receives a First Medical Certificate (Form 3) under the Act which does not nominate a medical review of the worker within a period of 14 days from the date the certificate is issued may be required, under section 64 or 65 of the Act, to submit himself for examination by a medical practitioner provided by the employer at any time from the date the certificate is issued.

(3) A worker who fails to attend a medical review, nominated on a First Medical Certificate in accordance with subregulation (1), may be required, under section 64 or 65 of the Act, to submit himself for examination by a medical practitioner provided by the employer at any time from the date of that non-attendance.

(4) An employer shall not require a worker to attend a medical review or examination —

(a) more frequently than once every 2 weeks; or

(b) at any time other than during reasonable hours.

".

8. Appendix I, Form 2B replaced

Appendix I, Form 2B is deleted and the following form is inserted instead —

"

FORM 2B

[Regulation 6AA]

Workers' Compensation and Rehabilitation Act 1981

[section 84I(1)(b)]

WORKERS' COMPENSATION CLAIM FORM

Employer Details
(*To be completed by employer after receipt from the worker*)

Name of policy holder: ……..……..……..
……..……..
Address: ……..……..……..
……..……..
Suburb/town: ……..……..
……Postcode: …..……..……..

Trading name of employer: .....……..…….....…
(e.g. Browns Pharmacy; ……..……
E.J.Imports) ……..…

Address of worker's usual ….……..……..……...
workplace or base: .....……..……...
……Postcode ……..……...
Major activity of workplace: .....……..……..…
(e.g.sheep or grain farming; .....……..……..
aluminium window screen .....……..……..
manufacturing) .....

Office Use only	ANZSIC CODE -

Insurance Co. …… Policy No. ……..……...
WorkCover No. W C …….. Claim No……..……
Insurer/Self Insurer to complete

EMPLOYER: Forward to your insurer within 3 full working days of receipt from the Worker

Injured worker details

Surname: *Mr/Mrs/Miss/Ms*.....
Other names: .....
Address: .....
..... Postcode: ……..
Phone No.: ……

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

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

Occupation (e.g. first class welder; accounts clerk) ……
Main tasks or duties performed? (e.g. welding of high pressure steam pipes; recording and paying accounts) ……
……
……

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

— direct employee?	❒ 1	Full Time	❒ F
— working director?	❒ 2		
— contractor?	❒ 3	Part Time	❒ P
— employee of contractor?	❒ 4		
— sub-contractor?	❒ 5	ASCO	
— other?	❒ 6		

Occurrence details

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

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

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

Were you	- on duty?	❒ 1	- travelling between home and work?	❒ 4
	- on duty & in a road traffic accident?	❒ 2	- doing something else, if so what? ……	❒ 5
	- on a work break?	❒ 3	……	

What actually happened and what caused the occurrence?
Include:
(i) what action was involved, e.g. fall, caught between, struck by moving object
.....
.....
(ii) what object/machine was involved, e.g. petrol fumes, wooden door frame
.....
.....
Describe:
(i) the most serious injury or disease caused by the occurrence, e.g. fracture, burn, cut, abrasion
.....
(ii) bodily location of the injury or disease, e.g. upper arm, ankle, eye
.....

Mechanism

Agency

Nature

Bodily Location

Occurrence report

Where did the occurrence occur? (e.g. store room, machinery shop)
……

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

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

When did you first report the occurrence? Date: / / Time: / /

To whom did you report the occurrence? Name / Title ……

If the occurrence was not reported immediately, state the reason: ……

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

Medical attention/history – this event

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? If not, give details: ……

Medical attention/history – similar or related previous events

4. Is the present injury or disability totally attributable to this occurrence? If not, give details: ……

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

6. Name & 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 so, from whom? ……

2. Give details of similar or related previous workers' compensation claims

Name & address of employer	Name of insurer (if known)	Nature of injury, disease or other claim

Injured 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 the provisions of section 59(2) of *the Workers' Compensation and Rehabilitation Act 1981*, I am required to notify my employer in writing within 7 days if I commence work with another employer after making a claim, or while receiving weekly payments of workers' compensation.

Dated this ……. day of ……... Year …….

Signature of worker ……. Signature of witness ……...

Consent authority (*to be signed at the option of the worker*)

I authorize any doctor who treats me (whether named in this certificate or not) to discuss my medical condition, in relation to my claim for workers' compensation and return to work options, with my employer and with their insurer.

Dated this ……. day of ……... Year …….

Signature of worker ……. Signature of witness ……...

IMPORTANT:
FAILURE TO PROVIDE YOUR SIGNATURE ON EITHER THE DECLARATION OR THE AUTHORITY ABOVE MAY DELAY A DECISION BY YOUR EMPLOYER ON YOUR CLAIM.

Insurer/Self-insurer to complete		Insurer/Self-insurer's Date Stamp
Estimated time off work — - less than one day……..❒ - 1-4 work days (inclusive)……...❒ - 5-9 work days (inclusive)……...❒	- 10-20 work days (inclusive)…...❒ - more than 20 work days……❒ - fatality……❒	

Front

Employer please complete

If the First Medical Certificate indicates the injured worker will be absent from the workplace for more than 3 working days and/or is unable to return to normal duties please complete the section overleaf and fax to the medical practitioner who provided the worker's First Medical Certificate **within 2 working days**.

% ==========

Employer, please provide the information overleaf to the injured worker.

Reverse

***ATTENTION* Dr.____________________________ Fax No. _____________________**

DETAILS TO BE PROVIDED TO MEDICAL PRACTITIONER

Please complete all sections of this form

WORKER'S DETAILS

Name in full: ……………………………………………………………………………………………...…
Address: ……………………………………………………………………………………………...…
Telephone: ……………………………………………………….. Date of birth ……../…………./……….…
Occupation: …..…………………………………………………………………………………………

INSURER'S DETAILS

Name of insurer: ………………………………………………………………………………………………
Contact person: …………………………………………………….. Telephone: …...………………………….

EMPLOYER'S DETAILS

Trading name: ……………………………………………………………………………………………….
Address of worker's usual workplace: …………………………………………………………………...
……….

ALTERNATIVE DUTIES FOR WORKER

Name of contact for liaison with medical practitioner: …………………………………………………………..
Role within organization: ………………………………………………………………………………...
Telephone: ……………………………………………………….…. Fax: …...……………………………..

❐ The above nominated contact is willing to discuss alternative duties and / or appropriate return-to-work options with the medical practitioner.

This organization can provide alternative duties which are attached. ❐ Yes ❐ No
This organization has a return-to-work / rehabilitation program for injured workers. ❐ Yes ❐ No

Signature ………………………………………………………………………………… Date …/…../……….

% =

INFORMATION TO BE PROVIDED TO THE INJURED WORKER

EMPLOYER please ensure this section is given to the injured worker.

Workers' Compensation Information for Injured Worker

- WorkCover WA is the government authority that administers the workers' compensation system in Western Australia. WorkCover WA is available as an independent third party to help answer your questions about how the workers' compensation system works. Contact WorkCover WA's Infoline if you need any information about the system.
- You should be notified by your employer's insurance company if your claim is accepted or not within three weeks of submitting your claim to your employer.
- You have the right to choose your doctor and vocational rehabilitation provider.
- Provide your employer with all medical certificates from your doctor as quickly as possible.
- Under section 59(2) of the *Workers' Compensation and Rehabilitation Act 1981* you must notify your employer in writing within 7 days if you commence work with another employer after making a claim, or while receiving weekly payments of workers' compensation.
- Regular contact between you, your doctor and employer is important and will assist the overall management of your claim. Make sure your doctor gives you a WorkCover WA brochure. This outlines what you should know about the system.
- An injury management system is in place and it is important you understand your rights and responsibilities in relation to your return to work. Contact WorkCover WA's Infoline to find out more.
- WorkCover WA runs free information seminars aimed at helping you understand the workers' compensation system. Contact WorkCover WA to arrange your attendance.

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

".

9. Appendix I, Form 3 replaced

Appendix I, Form 3 is deleted and the following form is inserted instead —

"

FORM 3
Workers' Compensation and Rehabilitation Act 1981
[sections 57A (1) (b), 57B (1) (b) & 61(1)]
FIRST MEDICAL CERTIFICATE

1. Worker's Details
First name(s): ..... Surname: .....
Address: .....
Telephone: ..... Date of birth: ……/……/…… Occupation: .....
❒ I have provided a WorkCover WA Injury Management brochure to the worker.

2. Employer Details
Name & address of worker's employer: ..
……

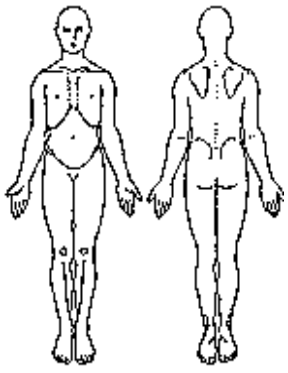
3. Consent Authority *(to be signed at the option of the worker)*

I authorize any doctor who treats me (whether named in this certificate or not) to discuss my medical condition, in relation to my claim for workers' compensation and return to work options, with my employer and with their insurer.

Worker's Signature …… Date ……

IMPORTANT: FAILURE TO PROVIDE YOUR SIGNATURE ON THE AUTHORITY ABOVE MAY DELAY A DECISION BY YOUR EMPLOYER ON YOUR CLAIM.

AFFECTED AREA



4. Details from Worker Date of injury/disease, etc: ..
Workplace location where incident occurred: ..
Worker's description of the injury/disease, etc: ..
……
Worker's description of how it occurred: ..
…..
…….

5. Medical Assessment
Clinical findings / diagnosis *(include possible complications, effect of prior injury or medical condition):*
……
……
……
……
In my opinion the above diagnosis **does** ❒ **/ does not** ❒ correlate with the injury/disease, etc. described to me by the worker.
INJURY MANAGEMENT

6. Fitness for Work It is my opinion that as from the date of this certificate the worker is:
FIT

❒ Fit to return to pre-disability duties, no further treatment required

❒ First and Final certificate
[See reg 7 and s. 61(1) of the Act]

❒ Fit to return to pre-disability 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. Other restrictions: ……..
- ❒ Avoid repetitive bending / lifting. ……
- ❒ Avoid repetitive use of body part: ……
- ❒ Avoid prolonged standing/ walking / sitting. ……
- ❒ Keep injured area clean and dry. ……

UNFIT

❒ Totally unfit for work for …… days from …….. to ……. (inclusive).

7. Medical Management

❒ Medication: …….

❒ Physiotherapy / Chiropractor *No. sessions recommended:* ……❒ Imaging ……...…

❒ Referred to hospital/specialist *(name)* ……..…

Other treatment: ..……...

……..……

……

Next appointment *(unless "First & Final Certificate")* **Date** …..…… **Time** …….……...

If the worker is not reviewed within 14 days, the worker may be required, under section 64 or 65 of the Act, to submit to a medical examination by a medical practitioner provided by the employer, on a day chosen by the employer.

8. Medical Practitioner / Employer Contact

❒ I have made contact with the employer and discussed alternative work options.

❒ The worker will be off work for more than 3 working days and/or is unable to return to normal duties. Employer please fax your contact details as I will contact you to discuss return to work options.

❒ The worker is able to return to normal duties. Contact with employer not necessary at this stage.

9. Medical Practitioner's Details

Name …….. Registration No. ……

Address……

Telephone …….. Signature ……...

Fax …….. Time & Date of examination ……

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

".

10. Appendix I, Form 3A amended

Appendix I, Form 3A is amended as follows:

(a) by deleting "Claim number:" and inserting instead —

" *Claim number: ";

(b) by inserting at the base of the Form the following —

"

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

".

11. Appendix I, Form 4 replaced

Appendix I, Form 4 is deleted and the following form is inserted instead —

"

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 wholly recovered from the effects of the disability.
- ❒ the worker has partially recovered from the effects of the disability.
- ❒ 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

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By Command of the Governor,

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


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