The Return to Work scheme provides timely, personalised support and services to workers and their employers following a work injury.

South Australians who have been injured at work may be eligible for income support and/or the reimbursement of medical expenses and other return to work services.

Before making a claim workers need to
> notify their employer about the injury
> see a doctor to get a Work Capacity Certificate.

How to make a claim

Step 1 Complete this form
Wherever possible, the worker and the employer should complete this form together. A representative, such as a treating doctor, a worker’s friend or a Return to Work Coordinator can assist the worker by completing information in the form with the worker’s consent.

Step 2 Sign the Medical Authority and declarations (page 4)

Step 3 Lodge this form
By sending it through to:
Injury Management and Wellbeing Advisor
Human Resources
Level 3
50 Rundle Mall Plaza

Important information for workers
> Report a work injury to your employer as soon as possible and talk to them about a plan to stay at or return to work.
> Talk to your doctor about work tasks you can still do and obtain a Work Capacity Certificate.
> Be actively involved in your treatment, recovery and return to work, or stay at work plans.

Important information for employers
> This form must be submitted to your claims agent within five business days of you receiving it.
> There are financial incentives for employers who forward the claim form together with the Work Capacity Certificate (if you have been given one) within five calendar days of receiving the form from the worker. For more information on financial incentives visit www.rtwsa.com
> Notifiable incidents
It is a legal requirement under the Work Health and Safety Act 2012 for a person who conducts a business or undertaking to notify SafeWork SA of:
  • the death of a person
  • a serious injury or illness of a person including immediate treatment for amputation, serious head, eye, burn and laceration injuries, separation of skin from underlying tissue, spinal injury or loss of body function; medical treatment within 48 hours of exposure to substance
  • a dangerous incident that exposes a worker or any other person to a serious risk to a person’s health or safety emanating from an immediate or imminent exposure, whether or not an injury has actually occurred.

Please notify SafeWork SA by calling 1800 777 209.
For more information about SafeWork SA please visit www.safework.sa.gov.au
Serious penalties could arise from failure to notify SafeWork SA of notifiable incidents. SafeWork SA receives ReturnToWorkSA claims data.

Need help?
If you have any questions about this form contact the Injury Management and Wellbeing Advisor on 35904 or via email
Section 1 - About this claim

1A - What is the claim for?
- Loss of wages
- Medical expenses
- Loss of wages and medical expenses

1B - Who is filling out this form?
When possible, it is suggested the worker and employer complete this form together.
- Worker
- Employer
- Both worker and employer completing the form together
- Other - Name: __________________________
  Relationship (i.e. Family, friend or representative): _____________________
  Phone: ________________________________

Section 2 - Worker details

Family name: _______________________________________________
Given names: _______________________________________________
Former names (if any): _________________________________________
Title: Miss Ms Mrs Mr
Date of birth: ______/_____/______
Gender: M F Other
Address: ___________________________________________________
Postal address (or if same write 'same as above'): ___________________
Daytime phone number: _____________________________
Mobile number: _____________________________
Email: ______________________________________________ (Note: Providing an email will ensure prompt receipt of important notices.)
Does the worker wish to identify as:
- Aboriginal
- Torres Strait Islander

Country of birth:
Does the worker need an interpreter?: Yes No
If yes, identify language (including Auslan): _______________________
Dialect: _______________________________________________
Is the worker an Australian citizen or permanent resident of Australia?
- Yes
- No
If 'No': __________________________
Type of visa: ______/_____/______

*Throughout this form 'injury' should be read as 'work related illness, condition or injury'*

Section 3 - Injury details

3A - Injury information
What was the circumstance in which the injury occurred? (tick one) while:
- Working at usual workplace
- Working, had a traffic accident—Police Report Number: _______________________________________
- Having a break
- Travelling to or from work
- Attending an approved course of study
- Working elsewhere
- Other (please specify): _______________________

Date and time of the injury: (or when was it first noticed)
Date ______/_____/______ Time ______:______
Did the worker stop work due to the injury? Yes No
If yes, date and time work was stopped:
Date ______/_____/______ Time ______:______
Has the worker resumed work? Yes No
If yes, date and time worker resumed:
Date ______/_____/______ Time ______:______
Has the worker returned to:
- pre-injury hours or less than pre-injury hours
Has the worker returned to:
- normal duties or modified duties

3B - Where did the injury occur?
Place (e.g. workshop floor): ___________________________
Address: ___________________________________________
Suburb / town: ___________________________ Postcode: __________

3C - Description of the injury
What is the injury and part of the body affected? (e.g. broken left lower leg, dermatitis of the hands, lower back strain):
____________________________________________________________________________________
What was the worker doing at the time of the injury? (e.g. lifting bags of cement from pallet to trolley):
____________________________________________________________________________________
What happened and how was worker injured? (e.g. repeatedly lifting heavy bags causing lower back pain):
____________________________________________________________________________________
Section 4 - Capacity for work and treatment

4A - Treating doctor’s information
Name: __________________________________________________________
Practice name: ________________________________________________
Practice phone: ________________________________________________
Practice address: ______________________________________________
Suburb / town: _______________________ Postcode: ________________
Hospital (if the worker was or is hospitalised): ____________________

4B - Work Capacity Certificate details
The worker’s Work Capacity Certificate covers the period from: _______/_____/______ to _______/_____/______

Section 5 - Employment details

5A - Employer’s name and address
Full company or business name: _________________________________
Trading name: ________________________________________________
Postal address: ______________________________________________
Suburb / town: _______________________ Postcode: ________________
Phone: ______________________________________________________
Email: _______________________________________________________ (Note: Providing an email address will ensure prompt receipt of important notices)
ReturnToWorkSA employer number: ____________________________
ReturnToWorkSA location number: ______________________________
Date worker started employment: _______/_____/______
Address of worker’s usual workplace (if different from above): ___________ _______/_____/______
Suburb / town: _______________________ Postcode: ________________

5B - Employer contact person for this claim
(e.g. Manager or Return to Work Coordinator)
Name: ______________________________________________________
Phone: _____________________________________________________
Position title: ________________________________________________
Email: ______________________________________________________

5C - Employment type
Is the worker any of the following? (if not leave blank)
☐ an apprentice  ☐ a trainee  ☐ a working director
If the worker is not an employee what is the relationship? (e.g. non-working director, sole contractor, partner):
__________________________________________________________________________

5D - Worker’s occupation and main tasks
Occupation: __________________________________________________
Main tasks: _____________________________________________________
__________________________________________________________________________

Section 6 - Income support

Please complete section 6 if claiming for loss of wages.

6A - Worker’s hours
Is the worker:
☐ permanent  or  ☐ casual
Normal hours per week? _________ hours
Regular hours each day of the week:
Mon Tue Wed Thu Fri Sat Sun
☐ ☐ ☐ ☐ ☐ ☐ ☐ OR
☐ tick if not regular hours (e.g. shiftwork)
Is the worker:
☐ full time  or  ☐ part time
If the worker works part time, what would their hours be if they worked full time? _________ per week (if known)

6B - Worker’s income details
What was the worker’s gross weekly wage at the time of the injury? $ _________
Does the worker normally work overtime?
☐ Yes  ☐ No
If yes, what is the average amount earned per week? $ _________
What are the average hours of overtime per week? _________
Does the worker receive non-cash benefits? ☐ Yes  ☐ No
If ‘Yes’ what is the benefit? (e.g. car, phone, computer)
__________________________________________________________________________
(Note: 12 months of wages information may be requested in order to determine Average Weekly Earnings.)

6C - Other employment details
Does the worker have any other current employment?
☐ Yes  ☐ No

Section 7 - EFT details

Payments and reimbursements are paid by EFT.

7A - Worker’s Electronic Funds Transfer (EFT) details
Bank name: __________________________________________________
BSB number: ___________/_______/_______
Account number: ______________________________________________
Account name: ________________________________________________

7B - Employer’s EFT details
Bank name: __________________________________________________
BSB number: ___________/_______/_______
Account number: ______________________________________________
Account name: ________________________________________________
Section 8 - Notification of injury

Notification details
When was the employer notified of the injury?

Date: ____________________________

Name of person notified: ________________________________________

Position/title of person notified: __________________________________

Person notifying: ☐ Worker ☐ Other, please specify: _______________________

Date claim form given to/completed with employer: ____________________________

Section 9 - Other information

Provide any other information relevant to the assessment of the claim:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Important information—read before completing sections 10 and 11

It is intended that the worker and employer complete this form together. If this is the case, the employer should complete section 10 and the worker section 11. If not, only the person (worker or employer) completing the form should sign the relevant section.

Section 10 - Employer declaration

I acknowledge that it is an offence against the Return to Work Act 2014 to make a statement that is false or misleading. The information I have provided is true and not misleading. I agree to advise ReturnToWorkSA:

> if my circumstances change
> if I become aware of any matter that would make the above information false or misleading
> of any change in the worker’s return to work status.

Employer’s full name (or authorised person): ______________________________________

Employer’s signature: ____________________________________________________________

Date: ____________________________

Section 11 - Medical authority & worker declaration

Only the worker can complete this section.

I give permission for:

> my medical experts to provide ReturntoWorkSA, my employer’s claims agent or my self-insured employer with information relating, and/or relevant to my work injury, condition or illness.
> any of my medical experts to receive x-rays, medical records or reports relating to my claim (including copies) for the purpose of writing a report about my injury, condition or illness related issue.
> ReturnToWorkSA or my employer’s claims agent, or my self-insured employer to release my personal contact information to an independent medical examiner for the purpose of an appointment reminder.

A photocopy of this medical authority is valid.

I acknowledge that it is an offence against the Return to Work Act 2014 to make a statement that is false or misleading. The information I have provided is true and not misleading. I agree to advise ReturnToWorkSA if:

> my circumstances change
> I become aware of any matter that would make the above information false or misleading.
> I undertake any employment (paid or unpaid), including self-employment, during my claim.

Worker’s full name: ____________________________

Worker’s signature: ____________________________________________________________

Date: ____________________________

Next steps

When the claims agent receives this completed claim form they:

> will contact the worker and employer
> may request additional information such as information to assist in determining the rate of weekly payments
> will assess and determine the claim for income support and/or medical services
> will arrange services to help the worker to recover and return to work. This may include visiting the worker and the employer if the worker is likely to be away from work for more than two weeks.

Workers of self-insured organisations should discuss the next steps with their employer.

Keep a copy of this completed form for your records.

Scan the QR code to visit our website for more information about making a claim and employer and worker rights and responsibilities. www.rtwsa.com