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 your line supervisor and the University of Adelaiades Injury Management and Wellbeing Advisor (ext 35904) 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 and your Work Capacity Certificate
By sending both forms through to:
Injury Management and Wellbeing Advisor
UNIVERSITY OF ADELAIDE
Human Resources Branch
Level 3, 50 Rundle Mall Plaza
Adelaide 5005

or

Scan both documents and email the Injury Management and Wellbeing Advisor (louise.dunn@adelaide.edu.au) with cc to the Manager, HSW Policy and Injury Management (deb.coulls@adelaide.edu.au)

### 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](http://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](http://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.

If you are not a staff member of the University of Adelaide or it's controlled entities, please contact Return to Work SA on 131855
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: __________________________________________
Expiry date: / / 

*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 / am/pm

Did the worker stop work due to the injury? Yes No
If yes, date and time work was stopped:
Date / / Time / am/pm

Has the worker resumed work? Yes No
If yes, date and time worker resumed:
Date / / Time / am/pm

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):
______________________________________________________
______________________________________________________
______________________________________________________

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

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