

Permanent impairment claim



State Insurance
Regulatory Authority

Workers Compensation Act 1987

Claimant name

Date of Injury

Claim number

This form should be submitted to make a claim for workers compensation for permanent impairment.

Please complete this form in BLOCK letters and use a black or blue pen.

If further space is required, attach a separate page.

This claim can only be made where the maximum medical improvement has been reached and the degree of permanent impairment is more than 10%.

This is considered to occur when the worker's condition is well stabilised and unlikely to change substantially in the next year with or without medical treatment.

Section 1: Have you previously submitted a *Worker's injury claim form* in respect of this injury?

Yes No If no, this claim form must also be completed.

Section 2: Worker's details

Title Family name

Given names

Street address

Suburb

State

Postcode

Date of birth (DD/MM/YYYY)

Section 3: Insurer details

Claim number, if known

Insurer

Section 4: Injury details

Do not complete if the claim relates to noise induced hearing loss. Go straight to section 6.

Date of injury (DD/MM/YYYY)

Clarification of date of injury if required (for example where the injury is a disease of gradual process)

Body system affected by the injury is

Percentage whole person impairment
claimed or percentage loss is

%

Section 5: Previous injury(ies) or pre-existing conditions

Do not complete if the claim relates to noise induced hearing loss. Go straight to section 6.

Are there any previous injury(ies) or pre-existing conditions to which any proportion of the impairment may be due?

Yes No

If Yes, give details of any such previous injury(ies) or pre-existing conditions.

Is there any previous employment to which any proportion of the impairment may be due?

Yes No

If Yes, give details of such employment. Include employer's name, address, occupation period of employment and if a compensation claim was made.

Have you received any lump sum workers compensation for your impairment due to your current or previous employment?

Yes No

If Yes, give details of workers compensation received. Include the date of injury, body system/part, % whole person impairment or loss, insurer, claim number and amount of compensation received.

Section 6: Hearing loss claims

Complete if the claim is for noise induced hearing loss.

Employers details. The employer to who notice of injury is given.

Business or company name

Street address

Suburb

State

Postcode

Business activity

If you are no longer employed by the above employer, what was your last day of employment with that employer? (DD/MM/YYYY)

Hearing loss claims continued over..

Employment history – Occupation

Give details of work history in any noisy workplace in Australia or overseas over the five year period preceding this claim. You should include any work as an employee, in self employment, partnership, military service or otherwise. Even if you are unsure how noisy the work may have been, include these details. Provide details of the employer/business/other name, address, occupation and period of employment.

Have you been paid any compensation for loss of hearing in Australia or elsewhere?

Yes No

If yes, please give details

Section 7: Documents attached in support of claim

This claim must be supported by a medical report from a medical specialist.

- If the injury was sustained before 1 January 2002 the medical report must support the amount of loss claimed
- If the injury was sustained on or after 1 January 2002, the medical report must be from a permanent impairment assessor listed on the SIRA website as trained in the assessment of the part or body system being assessed. The names of these specialists can be found at www.sira.nsw.gov.au
- If the claim relates to hearing loss a copy of the audiogram used by the medical specialist in preparing the report must also be attached

List the document, author and date

Section 8: Declaration

I, _____ (print name)
have read the information provided in this form. I declare that the information I have supplied in this form, and any attachment to this form, is true and correct to the best of my knowledge. I understand that the making of a false or misleading claim or a false or misleading statement in support of the claim is punishable by law and that if I make such a statement I may be prosecuted.

Signature of injured worker

Date (DD/MM/YYYY)