



INJURY NOTIFICATION TO GIO

In accordance with section 93 & 94 of the ACT Workers Compensation Act 1951, the employer must give the insurer notice of injury within 48 HOURS after becoming aware that the worker had received a workplace injury.

The employer may give notice orally, in writing or in electronic form to GIO via:

Phone: **02 6281 8806**
 Fax: **02 6282 9394**
 Email: gioactwc@gio.com.au

If given orally, this must be confirmed in writing within 72 Hours.

Note:

1. This is not a claim form
2. Completion and submission of claim forms are still required if a claim is lodged.
3. The employer is still required to maintain a Register of Injuries in the workplace.

1. Employer Details

Employer Name		Phone No:	
		Fax No	
ABN No:		Mobile No:	
Employer Address			
Name and Position of Authorised Person Reporting			
Workplace Contact Name (If different to above information)			
Email address		Contact's Phone No.	
		Contact's Fax No.	

2. Purpose of Notification – (Tick ALL applicable boxes)

NOTIFICATION ONLY	<input type="checkbox"/>	MEDICAL COSTS	<input type="checkbox"/>	TIME LOST COSTS	<input type="checkbox"/>
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3. Injured Worker Details

Surname		Given Name(s)		D.O.B.	
				Male/Female	
Street Address					
Suburb		Post Code			
Home Ph. No.		Occupation			
Work Ph. No.					

The information in this document is confidential. It may contain privileged information. Disclosure of any particulars on this form to third parties may breach the Privacy Act 1988 (Cwth) and is expressly prohibited by GIO General Limited without written approval by an authorised officer of GIO General Limited ABN 22 002 861 583.

4. Lost Time -

Date & Time Stopped Work:	Date: Time:	If Returned To Work, Date & Time :	Date: Time:			
Return To Work Duties:	Normal		Normal hours/week	Yes		No
	Suitable		Remains Off Work	Yes		No

5. Details of the Incident

Date of Incident?		Time of Incident	<i>am/pm</i>
Date Reported to Employer?		Time Reported	<i>am/pm</i>
Where Did Incident Occur?			
Incident Reported To?		Injured Body Part	
Injury Description			
How Did Injury Occur?			
Has the worker suffered a previous similar injury?			

6. Details of Treatment

Name of person providing first aid	
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Has the worker consulted a Doctor?	Yes		No	
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If yes, details below need to be completed in full for a notification to be compliant.

Name of Treating Doctor			
Name of Medical Practice			
Address			
Phone No:		Fax No: (if known)	

7. Witness Details

Name		Address	
Position			
Phone No:		Fax No: (if known)	
		Mobile No:	

8. Would you query the validity of this claim?

YES		NO	
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If "Yes" please comment indicating valid reasons.

Comment

Signature:		Date:	
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