FORM C – Catholic Church Insurance (Workers Compensation)

CCI – Initial Notification of Injury

Workers Compensation Insurance Policy No: 02.WCR.0020989	**Client No:**
Parish Name:	
Address:	
Employer contact:	
Phone no:	**Email address:**

Injured Workers Information

Name		D.O.B.	
		Employee No:	
Address:			
	Home:	Business:	
Telephone:	Mobile:		
		Interpreter: Yes/No	
	Male Female (please circle)		
Occupation:			
Language:			
Gender:			
Is the worker a member of a Religious Institute or a Minister of Religion?			
Has the worker previously sustained similar injuries to that of this notification? Please provide details;			

Employment Status Information:

Worker's Employment Status (please circle): Full time/ Part-Time/ Casual _____

No: of Hours worked per week: _____Award Weekly Wage (gross): $_____

Does the worker have employment other than with you? If yes please provide details below:

Details of Injury:

Date of injury:	Time of injury:
Describe how the injury Happened:	
What was the nature of the injury/disease? (fracture, sprain, burn)	
What part of the body was affected?	
Did the accident happen ➔ at work ❑ ➔ during an authorised break ❑ ➔ travelling to/from work ❑	
Where did the accident happen?	Was time lost due to the accident? If so when did the worker cease work?

Treating Doctor Information:

Dr's Name		Ph:
Hospital		Ph:

Contact Details of Person Making the Notification

Name of Person making notification:		**Date of Notification:**
Position:		Ph:
Address:		
Contact person (if different to the above)	Name:	Ph:

Documentation:

Has a medical certificate been issued? ✓ Yes/No (If faxing please attach) Date medical certificate was received: Date…….Expected Return to Work Date…… Diagnosis:…… Has a return to work plan been developed? ✓ Yes/NO (if yes please attach)
Any further information regarding the incident:

Signature of person making notification:

_____Date**:**_____