

SECTION A - PATIENT INFORMATION

Title: **Mr | Mrs | Ms | Miss | Dr**

| | | | |
|-----------------|---------|----------------|----------|
| Surname: | | First Name: | |
| Preferred Name: | | Date of Birth: | |
| Address: | | | |
| Suburb: | | State: | Postcode |
| Home Phone: | Mobile: | Work: | |

SECTION B - EMPLOYER DETAILS

Employer Name:

Address:

| | | |
|--|-------------------|---------------|
| Suburb: | State: | Postcode: |
| Phone: | Fax: | Email: |
| Name of Person Injury Reported to: | | Position: |
| Please indicate [✓] your type of claim: <input type="checkbox"/> WorkCover <input type="checkbox"/> InjuryNet <input type="checkbox"/> TAC (Transport Accident Commission) | | |
| Insurance Company: | | Claim Number: |
| Date / Time of Injury: | Injury Sustained: | |

SECTION C – PERMISSION TO RELEASE INFORMATION

I understand that the making of a false or misleading claim or false and misleading statement in support of the claim is punishable by law and that I may be prosecuted. I authorize and consent to any person who provides a medical service or hospital service to me in connection with an injury/condition to which this claim relates to provide upon request by the workers' compensation authority, my employer or insurer/claims agent, any information regarding the service relevant to the claim. I understand that my authority has effect and cannot be revoked for the duration of this claim.

Signature:

Date: