ProHealth
Family Medical Center Cranbourne

Work Cover / TAC Consent Form

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: ☐ WorkCover ☐ InjuryNet ☐ 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: