

Incident Lodgement

# Underwritten Workers’ Compensation Tasmania

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| **Policy Details** | | | |
| Policy Number: |  | Employer Name: |  |
| **Injury Details** | | | |
| Date of Injury: |  | Time of Injury: |  |
| Date Employer Notified: |  | Time Employer Notified: |  |
| **Employer Contact** | | | |
| Contact Person |  | Phone |  |
| Email | |  | |
| Postal Address | |  | |
| **Injured Worker** | | | |
| Name: | |  | |
| Date of Birth: |  | Phone Number: |  |
| Address: | |  | |
| **Injury Details** | | | |
| Location of Injury (e.g. Left Lower Leg): | |  | |
| Type of Injury (e.g. Burn, Strain) | |  | |
| What happened to cause the Injury / Incident: | |  | |
| **Medical Treatment** | | | |
| Does the Worker require medical treatment: | |  | |
| Has a medical Certificate been Issued: | |  | |
| **Workers Claim for Compensation** | | | |
| Does the worker wish to make a Claim for Compensation: | |  | |
| Do you require a Claim Form to be sent: | |  | |