

Hotel Employers Mutual Limited

ABN 34 124 091 470

SYDNEY

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Hotel Employers Mutual

Initial Notification Of injury - Fax Form

Notification No.

This form is to be used if an employee suffers a work-related injury and has not completed a claim form. Employers are required to notify the insurer within 48 hours of an injury. The shaded areas must be completed to be considered an "initial notification". Please supply as much information as possible to allow us to make payments and develop an injury management plan.

1 Employer's Particulars

Employer Name*	<input type="text"/>	Policy No.	<input type="text"/>
Business Address**	<input type="text"/>	Post Code	<input type="text"/>
Workplace Address***	<input type="text"/>	Post Code	<input type="text"/>
Contact Name	<input type="text"/>	Phone	<input type="text"/>
Contact Email	<input type="text"/>	Fax	<input type="text"/>
Nominated Rehab Provider	<input type="text"/>	Significant Injury	Yes <input type="checkbox"/> No <input type="checkbox"/>

*include trading name or cost centre where applicable **if policy no. unknown ***if different from business address

2 Worker's Particulars

Worker's Name	<input type="text"/>	Sex	Male <input type="checkbox"/> Female <input type="checkbox"/>
Address	<input type="text"/>	Post Code	<input type="text"/>
Phone	<input type="text"/>	DOB	<input type="text"/>
Permanent <input type="checkbox"/> Casual <input type="checkbox"/>		F/T <input type="checkbox"/> P/T <input type="checkbox"/>	
Interpreter No <input type="checkbox"/> Yes <input type="checkbox"/> Language <input type="text"/>		Hrs/Week	<input type="text"/>
Occupation	<input type="text"/>	Award Rate	\$ <input type="text"/>
Main Tasks	<input type="text"/>		

3 Injury Details

How Injury Occurred	<input type="text"/>	Injury Date	<input type="text"/>
Details of Injury	<input type="text"/>	Injury Time	<input type="text"/>
Accident Location	<input type="text"/>	Date Employer Notified of Injury	<input type="text"/>
Treating Doctor or Hospital (if admitted)	<input type="text"/>	Phone	<input type="text"/>
Dr/Hosp Address* *if phone. unknown	<input type="text"/>	Fax*	<input type="text"/>
Medical Cert From	<input type="text"/>	Incapacity	Total <input type="checkbox"/> Partial <input type="checkbox"/>
Second Injury	No <input type="checkbox"/> Yes <input type="checkbox"/>	Date Ceased work	<input type="text"/>
Claim Lodged	No <input type="checkbox"/> Yes <input type="checkbox"/>	Expected RTW Date	<input type="text"/>
Comments	<input type="text"/>	Date RTW Partial	<input type="text"/>
	<input type="text"/>	Date RTW Normal	<input type="text"/>
	<input type="text"/>		
Notifier's Name	<input type="text"/>	Contact No	<input type="text"/>
Relationship to Worker	<input type="checkbox"/> Worker <input type="checkbox"/> Employer <input type="checkbox"/> Other-specify		

Office Use Only

Criteria Met 1 - Min identifying information 2 - Medical information 3 - Injury work related 4 - Worker is a worker

Claim Forms Posted No Yes Injury on Journey form required No Yes