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: |  |