

Travel Incident


Agency details

| | |
|-------------------|--------|
| Agency name: | |
| Address: | |
| Contact name: | |
| Phone: | Email: |
| Risk/cost centre: | |

Claimant details

| | |
|--|-------------|
| Last name: | First name: |
| Date of birth: | |
| Address: | |
| Phone: | Email: |
| Relationship to agency (e.g. employee) | |

Incident details

| | | |
|--|-------|---|
| Date of incident: | Time: | am/pm |
| Where did the incident occur? | | |
| What was your destination? | | |
| Was your work related travel interrupted or deviated for any non-work related reason? Yes <input type="checkbox"/> No <input type="checkbox"/> if yes, for how long? | | |
| Provide details: | | |
| State clearly and fully how the incident occurred: | | |
| Did the incident involve a motor vehicle crash? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, complete the owner and driver details | | |
| Was an online crash report form completed? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, crash number: | | |
| Sketch the scene of the incident Directions: 1. Name the streets 2. Indicate direction with arrows ←→↑↓ 3. Show your vehicle <input type="checkbox"/> and the other vehicle(s) ■ 4. Indicate distances, e.g. 4m → ■ 5. Show accurately the position of any pedestrian (P) or vehicles involved in the incident and witnesses (W) 6. Show point of impact X 7. Show existence of road signs at intersections. | |  |
| Who is, or what was, considered to have caused the incident? | | |
| Why? | | |
| If any charges were laid or intimated against you, provide details: | | |

Owner and driver details (if applicable)

| | |
|----------------------------|----------------------|
| Owner's name: | |
| Address: | |
| Phone: | Email: |
| Make and model of vehicle: | Registration number: |
| Driver's name: | |
| Address: | |
| Phone: | Email: |
| Name of insurance company: | |

Other vehicle owner and driver details (if applicable)

| | |
|----------------------------|----------------------|
| Owner's name: | |
| Address: | |
| Phone: | Email: |
| Make and model of vehicle: | Registration number: |
| Driver's name: | |
| Address: | |
| Phone: | Email: |
| Name of insurance company: | |

Witness details

| | | | |
|--|------------------------------|-----------------------------|--------------------------|
| Were there any witnesses to the crash? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If yes, provide details: |
| Name: | | | |
| Address: | | | |
| Phone: | Email: | | |
| Name: | | | |
| Address: | | | |
| Phone: | Email: | | |

The Insurance Commission of Western Australia collects your personal information to assess and manage your workers compensation claim. During the course of your claim, we will continue to collect other personal information from you and/or other relevant parties (including hospitals, medical providers, employers, injury management and rehabilitation professionals etc) for the same purpose. Your information may be shared with other authorised parties where necessary and authorised by law. For further details on how we handle your personal information, please read our Privacy Policy at icwa.wa.gov.au/privacy.

Declaration

| | |
|--|-------|
| I declare that the details submitted are true and correct. | |
| Signed: | Date: |