Insurance Commission of Western Australia

Declaration of Employment

OFFICE USE ONLY

Claim number:

Incident date:

Government Insurance Division

Level 15,Tower 2, Mia Yellagonga
5 Spring Street
Perth WA 6000
GPO BOX L920
Perth WA 6842
Tel: (08) 9264 3333
icwa.wa.gov.au

Worker details:

I, Last name:	First name:			
of (address):				
Occupation:	Employer:			
Do solemnly and sincerely declare that: I am entitled to receive income compensation under the *Workers Compensation and Injury Management Act 2023*, and am receiving the payments due to me.				
List all employment (including self-employment)* and business activities that you have been engaged in since your accident on (date)				
Details of employer (including self-employment)	Period worked		Job title	Amount paid (gross weekly earnings)
	From	To		
Name: Address: Contact Details:				
Name: Address: Contact Details:				
Name: Address: Contact Details:				
Name: Address: Contact Details:				

*attach separate sheet if insufficient space

Privacy Notice

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 solemnly and sincerely declare that the particulars contained herein or hereto are true in substance and fact.

I take notice that under the provisions of *Section 32* of the *Workers Compensation and Injury Management Act 2023*, I am required to notify the Insurance Commission or the employer paying my income compensation should I commence work with another employer after making a claim or while receiving income compensation for incapacity.

Signature of worker: Date: