



Workers Compensation Claim Advice Slip

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

Last name:		First name:	
Phone:		Email:	
Date of birth:		Date of injury/recurrence:	
Employer:		Date of lodgement with employer:	
Address:			
Acceptance of claim recommended: Yes No Uncertain			
If no or uncertain, please state reasons:			

Employee status

<input type="checkbox"/> Industrial award <input type="checkbox"/> Non-industrial award <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary – end date: _____ <input type="checkbox"/> Contract – end date: _____ <input type="checkbox"/> External contractor	Hours per week: _____
	Invoicing rate: _____
	Rate of pay \$ _____ weeks 1- 26
	Rate of pay \$ _____ week 27 ongoing

Signed:	Date:
---------	-------