



# Recurrence of Injury

To be completed where a worker has lost further time following a return to work or where there has been a renewal of treatment of the original injury.

## Worker details

Last name:		First name:	
Address:			
Current employer:		Claim number:	
Nature of injury:			
Date of original injury:		Date of any further incapacity:	
Did you lose time off work? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, from what date?	Date of return to work:

## Recurrence details

Describe in detail where you were and what you were doing when the latest onset of symptoms or incapacity occurred:			
If a further incident occurred, please provide details of this further incident:			
Were there any witnesses to the onset of further symptoms? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, when and by whom?	
Witness name:		Address:	
State what symptoms, if any, you have been experiencing leading up to the latest onset of symptoms:			
What medical treatment have you been receiving prior to the latest onset of symptoms?			
State the names of treating doctors and dates of treatment:			
Doctor's name:		Date:	
Doctor's name:		Date:	
Give full details of your employment between the date of the original injury and current injury. Supply names of all employers, dates worked and occupation (attach separate sheet if required).			
Employer and occupation:		From:	To:
Employer and occupation:		From:	To:

## 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](http://icwa.wa.gov.au/privacy).

## Declaration

I solemnly and sincerely declare that the answers above and the particulars contained herein or annexed hereto relating to myself and the occurrence are true both in substance and in fact to the best of my knowledge and belief. You are required under s32 of the Workers Compensation and Injury Management Act 2023, to inform us within seven days of commencing paid work with another employer whilst receiving income compensation payments for your injury. I hereby authorise any doctor to divulge to my employer, or other insurer, information in relation to my claim for workers compensation which they may have acquired with regard to myself.

Signature:	Date:
Witness signature:	Date:
Name of witness:	