GOVERNMENT OF WESTERN AUSTRALIA

DFES
Department of Fire & Emergency Services

Workers' Compensation and Injury Management Branch
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Insurance Commission of Western Australia

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# Volunteer Injury Claim

## 1. Injured Person

| | |
|---|---|
| Last name: | First name: |
| Address: | |
| Date of birth: | Gender: Male ☐ Female ☐ |
| Phone: | Email: |
| At the time of the injury I was volunteering as a member of: SES ☐ VFES ☐ VFRS ☐ Marine Rescue WA ☐ Education and Heritage ☐ Cadets ☐ | |
| Brigade/Group/Unit name: | |
| Volunteer ID number: | |
| Normal occupation: | Self employed? Yes ☐ No ☐ Retired? Yes ☐ (when ) No ☐ |
| Name of employer: | Full time ☐ Part time ☐ Casual ☐ hours per week? |
| Contact name: | Contact number: |

## 2. Details of person to whom the compensation is to be paid, if different to above.

| | |
|---|---|
| Last name: | First name: |
| Address: | Phone: |

## 3. Injury details

| | |
|---|---|
| Date of injury: | Time of injury: ☐ am ☐ pm |
| Address where injury occurred: | |
| Describe fully how the injury occurred (if a motor vehicle involved also complete motor vehicle section of form): | |
| What action was involved (e.g. fall, struck by object)? | |
| What object/machine/substance was involved (e.g. fumes)? | |
| What were you doing at the time of injury? | |
| Where did the injury occur (e.g. storeroom, incident location)? | |
| What time did you start volunteering on this day? ☐ am ☐ pm | Incident No (FIRS): |
| To whom did you report the injury? | Rank/title |
| When did you report the injury? Date: | Time ☐ am ☐ pm |
| Have you completed a DFES Hazard Report? ☐ Yes ☐ No: | |

## 4. Witness details (if applicable)

| | |
|---|---|
| Name: | |
| Phone: | Email: |
| Name: | |
| Phone: | Email: |

## 5. Nature of injuries

| | | |
|---|---|---|
| Describe the injuries: | | |
| Bodily location: | | |
| Has the same part of the body been injured previously? ☐ Yes ☐ No: If yes, please explain: | | |
| Has the person been totally or partially incapacitated from engaging in, or attending to, his/her business or occupation as a result of the injuries?<br>Partial ☐ Total ☐ Provide details below: | | |
| **Total incapacity** From: To: | **Partial incapacity** From | To: |
| *Payslips or evidence of income for the 13 weeks immediately prior to injury will be required for weekly entitlements to be paid.* | | |
| How long has the person been confined to: | **Bed:** From | To: |
| | **House:** From | To: |
| | **Hospital:** From | To: |

## 6. Medical treatment

| | |
|---|---|
| Name of doctor who first treated you: | |
| Address: | Phone: |
| Name of your normal doctor: | |
| Address: | Phone: |
| Hospital/medical centre attended: | |
| Address: | Phone: |
| Name of physiotherapist or treating specialist: | |
| Address: | Phone: |
| Has the person required medical or surgical treatment in the past five years? ☐ Yes ☐ No: If yes, please provide details: | |
| Is there any other insurance that will cover this claim? ☐ Yes ☐ No: If yes, please provide insurance company and policy number: | |
| Is the person a member of any government or private health insurance fund or scheme? ☐ Yes ☐ No: If yes, please provide details: | |

## 7. Cadet Group Activity Students (if applicable)

| | |
|---|---|
| At the time of injury what school was the student attending? | |
| Was the student participating in an approved activity? ☐ Yes ☐ No | |
| Who was the responsible adult for the activity? | Phone: |

## 8. Motor vehicle crash details (if applicable)

| | |
|---|---|
| Driver name: | |
| Driver address: | |
| Driver phone: | |
| Make and model of vehicle: | Registration number: |
| Street and locality where injury occurred: | |
| Provide details of who you consider to have caused the accident and why. | |
| Has a claim been lodged against the Insurance Commission Motor Injury Insurance Division? ☐ Yes ☐ No | |

**9. Injured Person's Declaration and Consent Authority**

I solemnly and sincerely declare that each and every answer 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.

Signature of injured person, parent or guardian: Date:

Signature of witness: Date:

I authorise any doctor who treats me (whether named in this certificate or not) to discuss my medical condition, in relation to my claim for compensation and return to work options, with the Department of Fire and Emergency Services and with the Insurance Commission. Further, I consent to Department of Fire and Emergency Services, Insurance Commission and their appointed service providers collecting personal information, inclusive of sensitive information such as medical information about me and using it for the purpose of assessing and managing my compensation claim, including determining liability and whether my claim is true. This consent extends to the Department of Fire and Emergency Services and the Insurance Commission disclosing my personal information, inclusive of sensitive information, to other insurers, medical practitioners, rehabilitation providers, investigators, legal practitioners and other experts or consultants for the purpose of assessing and managing my claim. My personal information, inclusive of sensitive information, may also be disclosed as required or permitted by law. I have read all the information on this form regarding the consent authority and I consent to the Insurer dealing with my personal information in the manner described. **NOTE** failure to sign this consent may delay a decision by the insurer.

Signature of injured person, parent or guardian: Date:

Signature of witness: Date:

**10. Brigade/Unit/Group Declaration** (to be completed by Volunteer BGU senior representative)

To the best of my knowledge and belief I solemnly and sincerely declare that the particulars contained herein or annexed hereto relating to this claim are true both in substance and in fact.

Signature: Date:

Name, Rank/title: Phone:

**11. DFES Declaration** (to be completed by responsible manager, AO, DO or Superintendent)

To the best of my knowledge and belief the injured person and the person making the Brigade/Group/Unit Declaration are registered members of a DFES Brigade, Group or Unit.

I have personal knowledge of the injury ☐ Yes ☐ No

Signature of person having authority: Date:

Name, Rank/title: Phone: