Insurance Commission of Western Australia

Government Insurance Division
Level 13, Forrest Centre
221 St Georges Terrace
Perth WA 6000
GPO BOX K837
Perth WA 6842
Tel:(08) 9264 3333
icwa.wa.gov.au

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 ☐ No ☐ 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 ☐ No ☐ 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:

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. I take notice that under the provisions of Section 59(2) of the *Workers' Compensation and Injury Management Act 1981* I am required to notify my employer with seven days should I commence work with another employer after making a claim, or while receiving weekly payments of workers' compensation. I hereby authorise any doctor to divulge to my employer, or other insurer, information in relation to my claim for workers' compensation which he or she may have acquired with regard to myself.	
Signature:	Date:
Witness signature:	Date:
Name of witness:	

Attach medical certificates and reports.