Steadfast Taswide Insurance Brokers

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First Report of Injury

Please note that you should return this form or a copy of your own injury report form without the need for a completed claim form or medical certificates within 3 days of becoming aware of a work injury that may result in a claim or incapacity to the worker. However, we would request that you forward this additional information within 3 days of receiving the completed claim form from the worker.

Insured Name:	Policy No:	Client Code:
Workers Details		
Surname:	Given Name:	
Address:	Suburb:	
Telephone:	Mobile:	
Occupation:	Date of Injury:	D.O.B
The worker is a: ☐ Direct Employee ☐ Working Director ☐ Subcontractor		
How did the injury occur?		
Describe the worker's injury or condition (eg. Strained right knee)		
Worker's Wage Details		
Normal Weekly Earnings:	Ordinary Time Rate of Pay Per Week:	
Normal Weekly Hours:	Average Days Worked Per Week:	
Employer's Details		
Business Name:		
Address:		
Contact Person:	Tel./Mob: Tel:	Mob:
Is the injured worker currently off work? ☐ Yes ☐ No	Date Returned:	
Doctor's Details (if known)		
Treating Doctor's/Hospital Name:	Telephone:	
Notifier's Details:		
Person making Notification:		
Relationship to Worker or Employer:		
Signature:	Date:	