To be completed by an injured person who has been further incapacitated following a return to work or who has recommenced treatment for the original injury. Please attach any medical reports or certificates that you have.

*WA033*

Surname Other Names Original Claim No

Address

Current Employer Employer at the Time of the Original Disability

|  |  |  |  |
| --- | --- | --- | --- |
| Nature of Injury | Date of Original Injury | Date of Recurrence | Date of Return to Work (if further incapacity) |

Recurrence Details

1 a) Were you performing your usual duties when the latest onset of symptoms occurred? Yes 🞎 No 🞎

b) If Yes, describe your duties and what is was that specifically caused the recurrence?

c) If you were not performing your usual duties what were you doing?

2 Were there any witnesses to the onset of further symptoms? Yes 🞎 No🞎

If Yes, provide names, addresses and attach witness statements.

3 Did you report the onset of further symptoms? Yes 🞎 No🞎

If Yes, when? am/pm am/pm and to whom?

4 a) Were you experiencing any symptoms just prior to the latest onset? Yes 🞎 No🞎

b) If Yes, describe the symptoms.

c) Were you receiving any medical treatment prior to the latest onset of symptoms? Yes 🞎 No🞎

Provide names of treating Doctors and dates of treatment.

5 a) Have you changed employment since your original injury? Yes 🞎 No🞎

b) If Yes, provide names of employers, period of employment and occupation.

Injured Person’s Declaration

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 in substance and in fact to the best of my knowledge and belief. I take notice that under the provisions of Section 59(1) of the Workers Compensation & Injury Management Act 1981 (as amended) I am required to notify my Employer within 7 days should I commence work with another Employer after making this claim, or while receiving weekly payments of workers compensation. I hereby authorise any doctor to divulge to my Employer, or his or her insurer, information in relation to my claim for workers compensation, which he or she may have acquired with regard to myself.

Signature Of Injured Person Signature Of Witness Dated