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Document Details				
Existing title:	Workers Injury Claim Form (M form)	**Document title updated?**	Yes ☒	No ☐
Updated title:	Industrial Deafness Claim Form			

Existing fields	Changes	Comments
PERSONAL DETAILS	**1. Personal details**	
Title: Surname: Given names: Date of birth: Gender: [Male / Female] Home address: Post code: Postal address: Post code: Home phone number: Mobile phone number:	Title: Surname: Given name(s): Other/previous legal names Date of birth: Gender: [Male / Female / Other] Home address: State Post code: Postcode Postal address: (if different from above) State Post code: Postcode Home phone number: Mobile phone number: Email address	Addition of other names field to capture information such as worker's maiden name. Addition of 'other' option under gender in line with SIRA and most government body forms. Addition of email address field to streamline worker communication.
EMPLOYMENT DETAILS	**2. Employment details**	
Name of employer: Name of mine/establishment where injury occurred: Occupation: Year commenced in NSW coal mining industry:	Name of employer: Name of mine/establishment where injury occurred: Occupation: Year commenced in NSW coal mining industry: Are you currently employed and working in the NSW coal mining industry? [Yes / No > Date last worked: __] Employment history *Please provide details of your work history over the last five (5) years prior to making this claim (and earlier, if possible). You must include any work as an employee, in self-employment,*	Captures history to allow CMI to review any potential need to apportion hearing loss between more than one employer.

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	partnership, military service or otherwise. Even if you are unsure whether the work was noisy, please include these details. Employer Name and location Job title Description of your work duties Type of tasks, frequency over average day or week, machines and equipment Period YYYY – YYYY **If you require further space, please attach a separate letter with these details*	
INJURY DETAILS	**N/A**	
Date of injury: Time of injury: [am / pm] Date injury reported: Time injury reported: [am / pm] To whom was the injury reported: Position: Time shift commenced on day of injury: [am / pm] Did you cease work as a result of injury? [Yes / No] If yes, date and time work ceased: [am / pm] Part of body injured (e.g. left upper arm, lower back): Nature of injury (e.g. fracture, sprain): Was the body part injured normal prior to this incident? [Yes / No]	Date of injury: Time of injury: [am / pm] Date injury reported: Time injury reported: [am / pm] To whom was the injury reported: Position: Time shift commenced on day of injury: [am / pm] Did you cease work as a result of injury? [Yes / No] If yes, date and time work ceased: [am / pm] Part of body injured (e.g. left upper arm, lower back): Nature of injury (e.g. fracture, sprain): Was the body part injured normal prior to this incident? [Yes / No]	Removed as these questions were not appropriate for industrial deafness.
DETAILS OF INJURY	**N/A**	
For journey injuries, a separate "journey accident" claim form must be completed in addition to this claim form Explain in detail how the injury occurred and the task being carried out at the time: Place where you were when the injury occurred: Name of tool or machine being used at the time of injury: Were there any witnesses to the incident? (Yes / No] If yes, please provide witnesses names and contact details:	*For journey injuries, a separate "journey accident" claim form must be completed in addition to this claim form* Explain in detail how the injury occurred and the task being carried out at the time: Place where you were when the injury occurred: Name of tool or machine being used at the time of injury: Were there any witnesses to the incident? (Yes / No] If yes, please provide witnesses names and contact details:	Removed as these questions were not appropriate for industrial deafness.

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N/A	**3. Other details**	
	Have you been exposed to noisy environments outside of your employment? E.g. shooting, loud music. [Yes > Please provide details below / No > Go to Section 4] Activity Description of activity and exposure to noise Period	New section to capture information usually gathered when CMI send out the worker / worker's solicitor's initial correspondence. Capturing this information at this earlier stage improves efficiency and decreases paperwork for the worker.
PREVIOUS INJURIES	**4. Previous claims**	
Have you previously suffered any similar injuries or conditions? [Yes / No] If yes, please give details: Date of injury(s): Was this a work-related injury? [Yes / No] If yes, please provide name of employer:	Have you previously suffered any similar injuries or conditions? [Yes / No] If yes, please give details: Date of injury(s): Was this a work-related injury? [Yes / No] If yes, please provide name of employer: Have you made any claims for hearing loss previously? [Yes / No > Go to Section 5] If yes, who was the claim with (name of employer and insurer) and what was the outcome?	Amended for relevance to industrial deafness claims

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ADDITIONAL CURRENT EMPLOYMENT	**N/A**	
Do you have any additional current employers? [Yes / No] If yes, please provide name of employer: Address: Do you own your own business or are you self-employed? [Yes / No] If yes, please provide name of business: Address:	Do you have any additional current employers? [Yes / No] If yes, please provide name of employer: Address: Do you own your own business or are you self-employed? [Yes / No] If yes, please provide name of business: Address:	Removed as these questions were not appropriate for industrial deafness.
DEPENDANTS	**N/A**	
Full and accurate information regarding dependants is required. The persons listed must be totally or mainly dependent on the claimant for support. If dependants receive no income write “NIL”. Surname Given names Relationship to claimant Date of birth Weekly income Employers name	Full and accurate information regarding dependants is required. The persons listed must be totally or mainly dependent on the claimant for support. If dependants receive no income write “NIL”. Surname Given names Relationship to claimant Date of birth Weekly income Employers name	Removed as these questions were not appropriate for industrial deafness.

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Privacy Statement	**5. Privacy Notice**	
Information of opinions on this form that could reasonably identify you to another person are considered to be 'personal information' under the privacy legislation. CMI will only use or disclose your personal information for purposes that would reasonably be expected during the claim process, e.g. sharing your information with other service providers, medical practitioners involved in your claim. CMI will seek your permission before using your personal information for any other purposes. If you would like any further information in relation to CMI's privacy policy or if you have any concerns about how CMI is managing your personal information, please contact our office on (02) 8270 3200.	Information of opinions on this form that could reasonably identify you to another person are considered to be 'personal information' under the privacy legislation. CMI will only use or disclose your personal information for purposes that would reasonably be expected during the claim process, e.g. sharing your information with other service providers, medical practitioners involved in your claim. CMI will seek your permission before using your personal information for any other purposes. If you would like any further information in relation to CMI's privacy policy or if you have any concerns about how CMI is managing your personal information, please contact our office on (02) 8270 3200. CMI will collect your personal information (including sensitive information and health information) for the purpose of processing, assessing and managing your workers' compensation claim (Claim), including determining liability and whether your Claim is true. CMI is authorised to collect your personal information under the *Workplace Injury Management and Workers Compensation Act 1998* (NSW). CMI generally collects information from you, treating and other doctors, allied health professionals, employers and investigators. CMI may disclose your personal information to medical practitioners, rehabilitation providers, legal practitioners and other experts or consultants for the purposes of assessing and managing your claim. CMI may disclose your personal information to your representative, if you have authorised us to do so in writing. CMI may also disclose your personal information to the State Insurance Regulatory Authority (SIRA) which is authorised to use that personal information to fulfil its functions under the NSW workers' compensation legislation. CMI will seek your consent before using or disclosing your personal information for any other purposes. CMI is unlikely to disclose your personal information to an overseas recipient. CMI will handle your personal and health information in accordance with the *Privacy Act 1988 (*Cth) and the *Health Records and Information Privacy Act 2002* (NSW). A copy of our privacy policy is available on our website. Our privacy policy contains information about how you can: • access the personal information about you that is held by CMI; • seek the correction of that personal information; or	

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Existing fields	Changes	Comments
	• complain about a breach of the Australian Privacy Principles, and how we will deal with such a complaint. If you would like any further information in relation to CMI's privacy policy or if you have any concerns about how CMI is managing your personal information, please contact our office on (02) 8270 3200.	
INJURED WORKER'S DECLARATION	**6. Worker's declaration and consent**	
I declare that the particulars are true and correct, that I have not withheld any information, and that the injuries I have received were caused in the manner stated above, and in no other way whatsoever. I consent to CMI and its appointed service providers collecting using and disclosing my personal information in accordance with its privacy policy and in particular collecting personal information about me and using it for the purpose of assessing and managing my worker's compensation claim, including determining liability and whether my claim is true. I consent to CMI disclosing my personal information to medical practitioners, rehabilitation providers, legal practitioners and other experts or consultants for the purposes of assessing and managing my claim. I also consent to CMI disclosing my personal details to SIRA (State Insurance Regulatory Authority) which is authorised to use this information to fulfil its functions under the NSW workers' compensation legislation. I understand that while I am in receipt of weekly compensation benefits, I am required to notify CMI at once if any of the following occur: 1. I commence employment with another employer. 2. I commence my own business.	Print full name: Date of birth: I have read the information provided in this Worker's Injury Claim Form (including the Privacy Notice and Worker's Declaration Consent (Form). I declare that the particulars information that I have supplied in this Form, and any attachments to this Form is are true and correct., I declare that I have not withheld any information, and that the injuries I have received were caused in the manner as set out in this Form stated above, and in no other way whatsoever. I authorise and consent to the collection, disclosure and use of my personal information in accordance with CMI's privacy policy and the above Privacy Notice. CMI and its appointed service providers collecting using and disclosing my personal information in accordance with its privacy policy and in particular collecting personal information about me and using it for the purpose of assessing and managing my worker's compensation claim, including determining liability and whether my claim is true. I consent to CMI disclosing my personal information to medical practitioners, rehabilitation providers, legal practitioners and other experts or consultants for the purposes of assessing and managing my claim. I also consent to CMI disclosing my personal details to SIRA (State Insurance Regulatory Authority) which is authorised to use this information to fulfil its functions under the NSW workers' compensation legislation. I understand that while I am in receipt of weekly compensation benefits, I am required to notify CMI immediately at once if any of the following occur: 1. I commence employment with another employer or in my own business.	

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3. There is any change in my employment that affects my earnings. 4. Any of the abovementioned dependants cease to be dependent upon me. 5. If I change my address. I acknowledge my obligation under Section 57 of the Workers' Compensation Act 1987. I understand that if any information I have given is untrue, that my claims may be denied and that I may be prosecuted. Note: a photocopy of this authority shall be valid as original. Signature of injured worker: Date: Date received by employer:	2. I commence my own business. 3. There is any change in my employment that affects my earnings. 4. Any of the abovementioned dependants cease to be dependent upon me. 5. If I change my address. I have read and acknowledge my obligation under Section 57 of the Workers' Compensation Act 1987 as set out below:. *(1) A worker who is in receipt of weekly payments of compensation shall forthwith notify the person making those payments of:* *(a) the worker's commencing employment with some other person or in the worker's own business, or* *(b) any change in that employment that affects the worker's earnings.* *(2) A worker is not guilty of an offence under this section if the worker satisfies the court that the person to whom the matter was to be notified failed to inform the worker of the obligation to notify that matter.* *(3) This section applies even though the weekly payments of compensation are payable under an interim payment direction by the Registrar.* I understand that if any information I have given is untrue or incorrect, that my claims may be denied and that I may be prosecuted. Note: a photocopy of this authority shall be valid as original. Signature of injured worker: Date: Signature of employer: Date received by employer:	