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Document Details				
Existing title:	Workers Injury Claim Form (M form)	**Document title updated?**	Yes ☒	No ☐
Updated title:	Worker's Injury 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) 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: Address of employer Name of mine/establishment workplace where injury occurred: Occupation: Year commenced in NSW coal mining industry: Basis of employment [Full time / Part time / Casual / Contract / If contract, state period:]	Captures employment basis for accurate system recording

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Existing fields	Changes	Comments
INJURY DETAILS	**3. Incident details**	
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: incident Time of injury: incident [am / pm] Date injury incident reported: Time injury incident reported: [am / pm] To whom was the injury reported: Position: Name and position of person you reported the injury to *At the time of incident were you on your daily or periodic journey to or from work? [Yes > Go to Section **4** / No] 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] **Name of tool or machine being used at the time of incident ***Were there any witnesses to the incident? [Yes / No] ***If yes, provide witness names and contact details ****Part of body injured (e.g. left upper arm, lower back): *****Nature of injury (e.g. fracture, sprain):	
DETAILS OF INJURY	**4. Injury 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:	**For journey injuries, a separate "journey accident" claim form must be completed in addition to this claim form* ****Part of body injured e.g. left upper arm, psychological *****Nature of injury e.g. fracture, sprain SIRA Certificate of Capacity attached? [Yes / No] Have you returned to work with your employer? [Yes / No] If yes: How many hours are you working? What duties are you doing? [Full / Suitable/Light] Explain in detail how your recent the injury occurred and any the task(s) 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:	

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Existing fields	Changes	Comments
PREVIOUS INJURIES	**5. Previous injuries**	
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:	Was the part of body affected by this injury healthy prior to this incident? [Yes / No] Have you previously had any surgery and/or treatment on this part of the body? [Yes / No] Have you previously suffered any similar injuries or conditions? had another injury or personal injury claim that related to this injury? [Yes / No] If yes, please give provide: Details, including claim number(s) and insurer Date of previous injury(s) Was this / were any of these a work-related injury(s)? [Yes / No] If yes, please provide name of employer(s):	
ADDITIONAL CURRENT EMPLOYMENT	**6. Additional current employment**	
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 currently have any other additional current employers employment (paid or unpaid)? [Yes / No] If yes, please provide name of employer: Address: Employer's name and address Phone number Hours worked per week Do you own your own business or are you self-employed? [Yes / No] If yes, please provide name of business: Address:	

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Existing fields	Changes	Comments
DEPENDANTS	**7. Dependants**	
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 Do you support a spouse/partner? [Yes / No] If yes, please provide their: Full name Date of birth Weekly income Name of employer Do you support any dependant children? [Yes / No] If yes, please provide their: Full name Date of birth Weekly income Should any children claimed be in receipt of a weekly income, please provide the name(s) of their employer(s) Should any children claimed as dependant be over 17 years of age, please complete the following Full name Is the child still attending school? [Yes / No] If yes, what school year are they in? If no, what date did they finish? Will the child leave school at the end of this term? [Yes / No] If yes, on what date? Will the child continue education at school, college or university next term? [Yes / No]	Dependant information updated to reflect all information captured on CMI’s (separate) Dependancy Form.

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Existing fields	Changes	Comments
N/A	**8. Journey incident**	
	Was your injury sustained whilst on a daily or other periodic journey to or from work? [Yes > Complete parts A and B / No > Go to Privacy Notice and Workers Declaration and Consent] Part A – Incident details Usual starting time [am / pm] Usual ceasing time [am / pm] Exact time your journey commenced [am / pm] Mode of transport used Was the injury sustained travelling to or from your home and place of employment? [Yes / No] If yes, describe exactly where the incident happened Was the injury sustained travelling to or from a place other than your normal place of employment? [Yes / No] If yes, what was the purpose of the journey and who authorised it? Was this your normal route taken on date of incident? [Yes / No] Did you deviate/interrupt in any way from your usual route? [Yes / No] If yes, provide reasons How did the injury occur? Did you consume any alcohol or drugs, including medication prior to the accident? [Yes / No] If yes, provide details Have you lodged any other claim as a result of this incident? E.g. property damage, CTP, public liability etc. [Yes / No] If yes, specify the type of claim, name of the insurer and claim reference number Part B – Witnesses Were there any witnesses to the accident? [Yes / No] If yes, provide name(s) and contact details Was there a motor vehicle (including your own) involved in the incident? [Yes > Complete Parts C and D / No > Go to Privacy Notice and Workers Declaration and Consent] Part C – Traffic incident details Please provide details regarding the vehicle you were travelling in Driver's name Driver's address Registration Licence number Contact number Owner's name	Newly added section to combine Workers Injury Claim Form and Journey Claim form

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	Owner's address Licence number Contact number Please describe the weather and road conditions Please provide details regarding any other vehicle(s) involved in the incident (if more than one, please attach a separate list) Driver's name Driver's address Registration Licence number Contact number Owner's name Owner's address Licence number Contact number If you do not have the other drivers' details or vehicle registration Provide reasons why e.g. other driver left the scene What attempts you have made to identify the driver? Describe other vehicle(s) involved e.g. colour, make, model, distinguishing marks or observations *Please attach any images/photographs you may have of the incident with this form* Part D – Reporting and locality Was the incident reported to the police? [Yes / No] If yes, name of police station Date reported Police Event Number	
Privacy Statement	**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	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.	

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Existing fields	Changes	Comments
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 • 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.	

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Existing fields	Changes	Comments
INJURED WORKER'S DECLARATION	**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. 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.	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. 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.	

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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:	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:	