NORTHERN TERRITORY OF AUSTRALIA

Regulations 1993, No. 50*

Regulations under the *Work Health Act*

I, KEITH JOHN AUSTIN ASCHE, the Administrator of the Northern Territory of Australia, acting with the advice of the Executive Council, hereby make the following Regulations under the *Work Health Act*.

Dated 15 December 1993.

K.J.A. ASCHE
Administrator

AMENDMENTS OF WORK HEALTH REGULATIONS

1. PRINCIPAL REGULATIONS

The Work Health Regulations are in these Regulations referred to as the Principal Regulations.

2. NEW REGULATION

The Principal Regulations are amended by inserting after regulation 4 the following:

"5. PRESCRIBED AMOUNT

"For the purposes of section 3(10)(d) of the Act, the prescribed amount is 65% of the annual equivalent of average weekly earnings.".

3. GUIDES TO EVALUATION OF PERMANENT IMPAIRMENT

Regulation 9(1) of the Principal Regulations is amended by omitting "3rd edition" and substituting "4th edition".

* Notified in the *Northern Territory Government Gazette* on 22 December 1993.

Government Printer of the Northern Territory
Price $1.70

4. REPEAL AND SUBSTITUTION

Regulation 11 of the Principal Regulations is repealed and the following substituted:

"11. DECLARATIONS

"Declarations required or permitted to be made by or under the Act may be made before a person before whom a statutory declaration may be made under the *Oaths Act*.".

5. STATEMENT OF RIGHT TO COMMENCE PROCEEDINGS BEFORE COURT

Regulation 13 of the Principal Regulations is amended -

(a) by omitting "Form 5" and substituting "(1) Form 5";

(b) by omitting "sections 69(d) and 85(10)" and substituting "sections 69(1)(b) and 85(8)"; and

(c) by adding at the end the following:

"(2) Where the employer gives to the worker a completed form in accordance with Form 5, he or she shall also provide the worker with a copy of the completed form.".

6. NEW REGULATIONS

The Principal Regulations are amended by inserting after regulation 14 the following:

"14A. MEDIATION OFFICERS

"(1) The functions of a mediation officer appointed by the Minister for the purposes of section 91B of the Act are to -

(a) promote the resolution of a dispute between a worker and his or her employer under section 91B of the Act;

(b) to conduct discussions with each party to the dispute;

(c) where it appears to the mediation officer likely to assist in the resolution of a dispute, convene a conference between the worker, the employer and/or the employer's insurer;

(d) preside at the conference;

(e) keep a record in respect of the mediation of the dispute in accordance with regulation 14B;

(f) advise the worker of the results of the mediation of the dispute; and

(g) advise the worker and/or the employer of further proceedings he, she or they may institute and the time within which to institute such proceedings.

"(2) In performing his or her functions, a mediation officer referred to in subregulation (1) has power to -

(a) request the worker, the employer and/or the employer's insurer to attend and participate in a conference convened by him or her for the purposes of the mediation of the dispute;

(b) set the date, time and place of the conference;

(c) determine the commencement, adjournment (if any) and termination of the conference;

(d) direct the provision of information, being information on which a party to the dispute relies (including a medical report or any other report), by that party to the mediation officer or to another party to the dispute;

(e) impose a time limit within which information or a report referred to in paragraph (d) must be provided; and

(f) do such other things as are necessary or convenient to be done for the due and proper performance of his or her functions.

"(3) In the performance of his or her functions or the exercise of his or her powers, a mediation officer referred to in subregulation (1) shall -

(a) act promptly and efficiently;

(b) be impartial; and

(c) except to the extent necessary for the proper performance of those functions or exercise of those powers, maintain confidentiality.

"14B. PROCEDURE FOR MEDIATION

"A record kept by a mediation officer in respect of the mediation of a dispute shall comprise of -

(a) a description of the nature of the dispute;

(b) a description of the parties to the dispute; and

(c) the results of the mediation of the dispute.".

7. SCHEDULE

The Schedule to the Principal Regulations is amended -

(a) by omitting Form 3 and substituting the following:

"FORM 3

Section 82

NORTHERN TERRITORY OF AUSTRALIA

Work Health Act

Regulation 10

WORKERS COMPENSATION CLAIM FORM
and
EMPLOYER'S REPORT

To the Worker

- Fill in this form if you have had time off or incurred any costs because of a work related injury or disease
- Make sure you attach your copies of the workers compensation medical certificate to this form
- When you have filled in this form give it to your employer immediately
- If you can't fill in this form yourself you may get someone else to do it for you

To the Employer

- Make sure a separate form is filled in for each injured or ill worker
- Send the original and white copies of this form to your insurance company immediately (there may be a penalty if there is a delay of more than 3 working days)
- Make sure the copies of the workers medical certificates are included
- Give the blue copy back to the injured worker
- Keep the yellow copy for your records
- If a worker has died, do not fill in this form, please contact the Work Health Authority.

Help

You can also get help and more information from the

Work Health Authority
Minerals House
66 The Esplanade Darwin
Ph (089) 895010

Work Health Authority
Peter Sitzler Building
107 North Stuart Highway
Alice Springs NT 0870
Ph (089) 518682

For people outside Darwin Phone (008)019115 for the cost of a local call (NT only)

Insurer Claim No. Claim Number

To the Insurer
Date Claim form received / /
Date claimant notified / /
Accept/Reject/Defer Reason

1. ABOUT YOU

Mr Mrs Ms Miss

Surname or Family Name

First or given names

Sex: Male Female

Postal Address

Residential Address

Telephone No. Home Work
Date of Birth
Country of Birth
Language spoken at home
Marital Status Single Married De facto
Worker's Dependents Spouse Children
Other (please specify)

2. ABOUT YOUR JOB

Your Occupation at the time of injury/disease.
Include here the main job you do and your job title.

Do you work Full time Part time
Are you Permanent Temporary Casual
Does your employer deduct P.A.Y.E tax from your pay?
No Yes
Do you have other paid employment? No Yes
If yes give details:
Full name of employer

Address

3. ABOUT YOUR CLAIM

Where did the injury/disease occur?
A At the workplace at which I am normally based.
B Working elsewhere
C While I was having a break
D Travelling to or from work
J Travelling whilst on duty
Other - give details below

Tell us the exact location or address where the injury/disease occurred.

When did your injury happen or you first notice the disease?
Date / / Time am/pm

4. ABOUT THE INCIDENT

Please tell us:
. What were you doing at the time.
. How the accident happened or what caused the disease.
. Include the object or substance that caused the accident e.g grinder, drill, etc.

5. ABOUT YOUR INJURY/DISEASE

Include here:
. part of body affected
. type of injury or disease e.g fracture, burn etc.

If more than one injury which is the most serious?

6. PREVIOUS EMPLOYERS

Could the injury/disease have been contracted in previous employment? No Yes

Name of employer

Address

Period of employment From / / to / /

7. WITNESSES

The name and address of any persons who were present at the time of injury

8. OTHER INFORMATION

Did you report the injury or disease to your employer?
No Reason
Yes
. Date injury/disease was reported / /
. Time injury/disease was reported am/pm

Name of the person you reported it to

Position in the company

Did you stop work because of your injury or disease?
No Yes
. Date you stopped work / /
. Time you stopped work am/pm
. Time you started work on that shift am/pm

Have you started back at work?
No Yes
Date you started back / /

Did you get medical treatment following your injury/disease?
No Yes
Name and address of the doctor

Dates you were treated / / / /
Were you admitted to a hospital?
No Yes
Name and address of hospital
Are you still receiving treatment?
No Yes
Name of the person treating you

Have you suffered from a similar injury/disease before?
No Yes

Name of the doctor who treated you

Address of the doctor

Type of injury/disease

When did the injury/disease occur / /
Have you claimed worker's compensation before?
No Yes SEE NOTE 1 ON THE BACK

If yes attach details as follows:
. When was the claim
. Who was your employer
. Who was the treating doctor

DECLARATION

I declare that the information I have shown in this form is true and correct and I have told you everything I know about the circumstances relating to my work related injury or disease.

Signature

Date handed to employer / /

If you are completing this form for the diseased or injured person give your name and address below.

A CLAIM FOR WEEKLY BENEFITS MUST BE ACCOMPANIED BY 2 COPIES OF THE PRESCRIBED MEDICAL CERTIFICATE. IF THESE CERTIFICATES ARE NOT ATTACHED, THE CLAIM IS NOT VALID.

AUTHORISATION FOR MEDICAL INFORMATION

I the undersigned hereby authorise any medical practitioner or other health service provider (including any hospital), to release all information concerning my injury/disease for which I am claiming (including the history of that injury or disease), to the Work Health Authority and to my employer's Work Health insurance company.

NOTE: This authorisation must be completed, otherwise your claim will not be considered.

Signature Date

I am willing that a photocopy of this authorisation be accepted with the same authority as the original

Signature Date

EMPLOYER'S REPORT ON INCIDENT (ALL SECTIONS MUST BE COMPLETED)

9. EMPLOYER INFORMATION

Registered business name

Address for correspondence

Telephone Fax

What is your "trading name" if different from business name?

Name of the person who can be contacted in relation to this report.

Position in the company.

Date claim received from worker / /

10. INSURANCE DETAILS

What is your workers compensation insurer's name?

What is the policy number?
What is the expiry date of the policy / /

11. ABOUT THE INJURED OR DISEASED WORKER

What was the workers gross weekly wage before the injury or disease.
$

Does this amount include any allowances? If yes attach details.
Yes No
How many hours does the worker normally work each week?
Hrs
Does the worker normally work overtime or shiftwork?
Yes No

SEE NOTE 2 AND 3 ON THE BACK

Where within your establishment does the worker normally work?
NOTE: Your answer here must tell us the actual section and address of the workplace where the worker does the majority of his or her work. If the worker works at multiple locations, tell us where the worker is normally based.

How many people are employed at this particular location? (i.e at the address above, at the present time)

1 - 4	50 - 99
5 - 9	100 - 199
10 - 19	200 - 499
20 - 49	500 +

When was the worker first employed by you?
/ /

Give details of other circumstances which would assist the Insurer to assess the claim (e.g. Do you query the validity of the claim?)
Yes No

In my opinion

What is the type of industry at the establishment where the worker normally works:

SEE NOTE 4 ON THE BACK

12. MORE THAN ONE PERSON INJURED

Was more than one person injured in the incident described in section 4.
No Yes
Please describe what happened, including the date and address where this happened.

13. REPORTABLE ACCIDENT?

Was this incident reported to the Work Health Authority as a notifiable accident?
Yes No

SEE NOTE 5 ON THE BACK

If yes, date notified: / /

DECLARATION

I declare that all the information I have provided in this report is true and correct and I have told you everything I know about the circumstances surrounding this worker's injury or disease.

Signature Date / /

Name of the person who has filled in this form

Position in the company

NOTES ON CLAIM FORM

FOR THE WORKER

NOTE 1
This information is required to determine if the present injury or disease may be related to a previous incident.

FOR THE EMPLOYER

NOTE 2
If Claimant has no fixed hours and is employed on a casual basis, please state the average number of hours worked per week. If no fixed hourly rate of pay applies then the earnings over the same period must also be averaged. (Where possible, please provide a copy of previous pay sheet/slip to substantiate regular hours)

NOTE 3
If a regular or fixed pattern of overtime and/or shifts are worked, you must confirm in writing the basis on which it is worked i.e. for how long has the claimant been working these shifts and what is the regularity.

NB. Do not let the provision of this information cause delay in giving this claim to your insurer. However, you will need to discuss these details, with your insurer, as soon as practicable after giving them the claim.

NOTE 4
You must state the main type of activity, business or service you provide in which the injured worker was involved. You do not put the actual occupation of the worker.

eg if you are a gold mining company and the injured worker is a driver, you would put down 'gold mining'.

NOTE 5
Regulation 46 of the Work Health (OH&S) Regulations requires that the following accidents are reported to the Authority as soon as possible.

- an accident or occurrence causing the death of a person;
- an accident or occurrence causing or, on the basis of medical advice, appears likely to cause a worker to be absent from work for 5 or more working days;

- an accident or occurrence where a worker receives an electric shock;
- an accident or occurrence where a worker is injured and admitted to hospital as an in-patient following exposure to a hazardous substance;
- an accident or occurrence where a person, other than a worker, is injured as a result of a workplace activity or by designated plant;

BENEFITS ARE:

Weekly benefits for incapacity, costs of medical treatment, reasonable rehabilitation costs, benefits for permanent impairment, and death benefits."; and

(b) by omitting Forms 5 and 6 and substituting the following:

"FORM 5

Sections 69 and 85

NORTHERN TERRITORY OF AUSTRALIA

Work Health Act

Regulation 13

WORK HEALTH

ADVICE TO A WORKER OF REJECTION, CANCELLATION OR REDUCTION OF WORKERS COMPENSATION AND ADVICE OF THE WORKERS RIGHT TO COMMENCE PROCEEDINGS FOR RECOVERY

Dear

Pursuant to your claim for payment of benefits as prescribed under the *Work Health Act*. You are hereby advised that your employer hereby

DELETE AS NECESSARY

Disputes liability for your claim pursuant to section 85 of the *Work Health Act*.

Cancels payment of weekly benefits to you pursuant to section 69 of the *Work Health Act*.

Varies the amount of weekly benefits payable to you pursuant to section 69 of the *Work Health Act* to the sum of ..... per week.

The reasons for this decision are:

You have the right to contest this decision in the Work Health Court and/or request mediation.

If you wish to have mediation simply complete the request below and send this form by post, or deliver it, to the Mediation Officer within 14 days of your receipt of this notice.

- Mediation will then be conducted within 14 days of the Mediation Officer's receipt of your request.
- The mediation will not be part of a court process.
- The mediation may involve you in a meeting with the Mediation Officer and Insurer.
- The mediation will be confidential.
- You can be represented at any mediation meeting if you wish, e.g. friend, union representative, lawyer.
- The mediation will not involve any legal costs unless you bring a lawyer.

If you are not satisfied with the outcome of the mediation, you may apply to have the matter resolved through the Work Health Court (as set out on this form).

N.B. You may make application to the Work Health Court without first asking for mediation.

If you wish to contest the decision in the Work Health Court you must make an application to the Court within 28 days of receiving this notice. If you fail to do this, you may make an application to the Work Health Court to waive the time limit.

Applications to the court disputing the rejection, cancellation or variation of your claim can be made at any Local Court in the Northern Territory.

After the application has been filed by the Registrar, you will be given a date (usually within 14 days) for a compulsory conciliation conference.

If you have any further queries about your rights under Work Health, please contact the Work Health Authority, Minerals House, 66 The Esplanade, Darwin N.T. 0800 or GPO Box 2010, Darwin N.T. 0801. Phone (089)895010. Toll free outside Darwin (008)019 115.

REQUEST FOR AN INDEPENDENT REVIEW

The Mediation Officer
C/- Work Health Authority
GPO Box 2010
DARWIN NT 0801
Minerals House
66 The Esplanade
DARWIN

I hereby request mediation to attempt to settle my claim as shown on this form.

Name:

Postal Address:

Phone No: (home): (work)

DO NOT DETACH

- Send or deliver one complete document to the Mediation Officer.
- Keep other copy of the document for your records.

"FORM 6

Section 130

NORTHERN TERRITORY OF AUSTRALIA

Work Health Act

Regulation 16

PAYMENT DECLARATION

See notes on reverse before completing this form

Insurer:

Employer details:

Name:
Postal address: Post code:
Office address: Post code:
Telephone:
Policy Number: Expiry date:

Important:
Please supply Australian Company Number (if applicable):
A.C.N.:
You are obliged under section 130 of the *Work Health Act* to complete this wage declaration within 28 days of your Policy's expiry date.

I (Name and address),
do solemnly and sincerely declare the following details:

Actual Amounts Paid in Previous Period
Estimate of Payments for Future Period

A. Ordinary Employees

Occupation	Number of Employees	Gross Amount Paid $	Occupation	Number of Employees	Gross Amount Estimated $

If you require Family members or Company directors covered under this Policy complete Sections "B" or "C".

B. Immediate Family Members

Full name	Relationship to Employer	Occupation	Gross Amount Paid $	Occupation	Gross Amount Estimated $

C. Company Directors

Full name	Occupation	Gross Amount Paid $	Occupation	Gross Amount Estimated $

See notes on reverse concerning signature of person making declaration.
Declared at the day of 19
Signature:
Before me (Witness): Print Name:
Address:
Note: A person wilfully making a false statement in a Statutory Declaration is liable to substantial penalties.

NOTES

Who will be covered under the new definition?
All workers who:

- have Pay-As-You-Earn (PAYE) tax deducted from their pay;
- would have had PAYE tax deducted from their pay but because they had only been employed for a short period the actual deductions had not commenced; or

- would have had PAYE tax deducted but their payments, combined with any Taxation Rebates they may be claiming, put them below the PAYE tax threshold.

as well as:

- a person or class of persons included by Regulation (e.g. St Johns Ambulance Volunteers);

- Fire Brigade, Bushfires and Emergency Services Volunteers.

Signature of person making declaration

This form is a statutory declaration and must be signed before a person who attained 18 years of age. Regulation 16 of the Work Health Act also provides that the Declaration must be signed by certain persons depending upon the organisational status of the employer.

(a) Where the employer is a natural person - the form must be signed by the person.

(b) Where the organisation is a partnership - the form must be signed by a partner.

(c) Where the organisation is a company, within the meaning of the Companies Act - the form must be signed by a director or secretary of the company.

(d) Where the organisation is a foreign company within the meaning of the Companies Act - the form must be signed by a director, the secretary or agent in the Territory of the foreign company.

(e) Where the organisation is an incorporated association within the meaning of the Associations Incorporation Act - the form must be signed by the Public Officer.

NOTES

GROSS PAYMENTS INCLUDE:

For wages and Salary Earners, Family Members and Company Directors.

(i) Wages, Salaries, bonuses, allowances, commission and all other remuneration paid, including pays in respect of holidays, sickness and long service leave.

(ii) Overtime.".