NORTHERN TERRITORY OF AUSTRALIA

Regulations 1989, No. 5*

Regulations under the Work Health Act

I, ERIC EUGENE JOHNSTON, 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 1 March 1989.

E.E. JOHNSTON
Administrator

AMENDMENTS OF WORK HEALTH REGULATIONS

1. DEFINITION OF "WORKER"

Regulation 3A of the Work Health Regulations is amended -

(a) by omitting from paragraph (a) "the vessel; and" and subsituting "the vessel;"; and

(b) by omitting from paragraph (b) "this regulation," and substituting the following:

"this regulation;

(c) a person registered as a foster parent under the Community Welfare Act caring for a child placed in the person's custody under an agreement under that Act; and

(d) a person, other than a person referred to in paragraph (c), caring for reward or gain, whether monetary or otherwise, in the person's place of residence of another person's child,".

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* Notified in the Northern Territory Government Gazette on 1 March 1989.

Government Printer of the Northern Territory

2. MINIMUM RATE OF COMPENSATION

Regulation 7 of the Work Health Regulations is amended -

(a) by omitting ", and the prescribed period is 2 years from and including 1 January 1987" and substituting "increased by the percentage difference between the average weekly earnings as at 1 January 1987 and the average weekly earnings at the time that the relevant payment becomes due"; and

(b) by adding at the end the following:

"(2) For the purposes of section 65(7) of the Act, the prescribed period is 4 years from and including 1 January 1987.".

3. SCHEDULE

The Schedule to the Work Health Regulations is amended -

(a) by omitting Form 3 and substituting the Form in Schedule 1 to these Regulations; and

(b) by omitting Form 6 and substituting the Form in Schedule 2 to these Regulations.

SCHEDULE 1

Regulation 3(a)

"FORM 3

Regulation 10

WORKERS COMPENSATION CLAIM FORM and EMPLOYER'S REPORT

WORK HEALTH ACT 1986

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
- Do not fill in this form if you are an Independent Contractor and you hold a Certificate of Exemption from the Work Health Authority
- You can also get help and more information from the Work Health Authority, Minerals House, The Esplanade Darwin (089) 89 5010
- For people outside Darwin ring (008) 01 9115 for the cost of a local call (NT only)

To the Employer

- Make sure a separate form is filled in for each injured or ill worker
- **Send the Red 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 days)**
- Make sure the copies of the worker's medical certificates are included
- Give the Blue copy back to the injured worker
- Keep the Yellow copy for your records
- You can also get help and more information from the Work Health Authority, Minerals House, The Esplanade Darwin (089) 89 5010
- For people outside Darwin ring (008) 01 9115 for the cost of a local call
- If a worker has died, do not fill in this form, please contact the Work Health Authority

(FORM 3 - continued)

To the Insurer
- Date claim form received ..../......../.......
- Date claimant notified ..../......../.......
- Accept/Reject Defer Reason ....

Insurer Stamp

Claim number

Workers' Compensation Claim

Page 1

About You

1 Surname or family name

First or given names

2 Sex Male ☐ Female ☐

3 Your Postal Address

Postcode

4 Your contact telephone number

5 Your date of birth / /

About your job

6 Your occupation at the time of injury or disease.

INCLUDE HERE THE MAIN JOB YOU DO AND YOUR JOB TITLE

7 are you
- an apprentice? Yes ☐ No ☐
- a trainee under the Australian traineeship system? Yes ☐ No ☐

About your claim

8 Where did your injury/disease occur?

A ☐ While I was working at usual workplace

B ☐ While I was working elsewhere or travelling on duty

C ☐ While I was having a break

D ☐ Travelling to or from work

☐ other

SEE NOTE 1 ON THE BACK

9 Tell us the exact location or address where your injury or disease occurred?

Postcode

10 When did your injury happen or you first notice the disease?

Date / / Time

About the incident

11 Please tell us:
- about all the events which led to the injury or disease
- what you were doing at the time
- how the accident happened or what caused the disease
- include the object or substance that caused the accident eg. grinder, drill etc.

About your injury/disease

12 Include here:

- part of body affected

- type of injury or disease eg. fracture, burn etc.

Previous employers

13 Could the injury/disease have been contracted in previous employment?

Yes ☐ No ☐

Name of employer

Address

Postcode

Period of employment / / to / /

Witnesses

14 The name & address of any person who saw what happened to you

(FORM 3 - continued)

Worker's Compensation Claim

Page 2

Other information

15 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

Name

Position in the company

16 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

17 Have you started back at work?

No [ ] Yes [ ] SEE NOTE 2 ON THE BACK

- Date you started back / /
- Time you started back am/pm

18 Did you get any medical treatment following your injury or disease?

No [ ] Yes [ ]

- Name and address of the doctor and/or health worker

Postcode

- Dates you were treated / / / /

19 Were you admitted to a hospital?

No [ ] Yes [ ]

- Give name and address of hospital

Postcode

- Period of time you were in hospital

/ / to / /

/ / to / /

20 Are you still receiving treatment?

No [ ] Yes [ ]

- Name of the person treating you

21 Have you suffered from a similar injury or disease before?

No [ ] Yes [ ]

- Name of the doctor who treated you
- Address of the doctor
- Type of injury or disease
- When did the injury or disease occur?

22 Have you claimed worker's compensation before?

No [ ] Yes [ ] SEE NOTE 3 ON THE BACK

- Name of employer
- Include address
- Type of injury or disease
- When did the injury or disease occur? / /
- How long were you off work?
- Amount of compensation paid to you $

Declaration

23 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

Postcode

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 my medical practitioner/s or other health service provider, to release all information concerning my work injury/disease for which I am claiming, to the Work Health Authority and to my employer's Work Health insurance company.

SIGNATURE [ ] Date / /

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

SIGNATURE [ ] Date / /

(FORM 3 - continued)

Employer's Report on Incident ALL SECTIONS MUST BE COMPLETED Page 3

24 Business name, address for correspondence and phone number?

Postcode

Telephone

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

Position in the company

26 Date claim received from worker / /

Insurance details

27 What is your insurer's name?

28 What is the policy number?

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

About the injured or diseased worker

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

31 How many hours does the worker normally work each week? Do not include overtime. hours
SEE NOTE 4 ON THE BACK

32 Where within your establishment does the worker normally work?
SEE NOTE 5 ON THE BACK

Postcode

33 How many people are employed at this particular location?

34 When was the worker first employed by you? / /

35 Do you have any additional or different details to those provided by your worker on the claim form?

No ☐ Yes ☐

- Please tell us exactly what is different and what you think it should be

36 What is the type of industry at the establishment where the worker normally works?
SEE NOTE 6 ON THE BACK

More than one person Injured

37 Was there a major event where more than one person was injured e.g. fire, explosion?

No ☐ Yes ☐

- Please describe what happened including the date and address where this happened

About the incident

38 Did the incident happen:

- on a mine site	No ☐	Yes ☐
- on a construction site	No ☐	Yes ☐

39 Did the incident involve:

- licensed machinery SEE NOTE 7 ON THE BACK	No ☐	Yes ☐
- hazardous materials SEE NOTE 8 ON THE BACK	No ☐	Yes ☐
- electric shock	No ☐	Yes ☐

Declaration

40 I declare that all the information I have shown 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

(FORM 3 - continued)

NOTES ON CLAIM FORM

FOR THE WORKER

NOTE 1

If your answer is 'other', please specify your activity in the space provided on the form, such as 'travelling to/attendence at training school', 'travelling to/attendence at medical centre' or 'travelling between employers premises' (if you have more than one job)

NOTE 2

If you have gone back to work and subsequently stopped work again because of that particular injury, please include all the dates you started work and then had to stop on a separate sheet of paper and attach it to the claim form.

NOTE 3

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

FOR THE EMPLOYER

NOTE 4

In the case of a worker who is required by the terms of employment to work fixed hours, not being hours of overtime, normal weekly hours are the number of hours so fixed

or

in the case of a worker not required to work a fixed number of hours each week the normal weekly hours are the average weekly number of hours, not being hours of overtime, worked during the 12 months immediately preceeding the date of this injury.

NOTE 5

Your answer here must tell us the actual section and address of the work place where the worker does the majority of his or her work. If the worker is employed outdoor in work, tell us where the worker is normally based.

NOTE 6

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.

e.g. If you are a gold mining company and the injured worker is a driver, you would put down 'gold mining'.

NOTE 7

'Licensed machinery' means any piece of machinery licensed by the Work Health Authority under the Inspection of Machinery Act.

NOTE 8

'Dangerous Goods' means any substance which is defined by the Dangerous Goods Act administered by the Work Health Authority.

BENEFITS ARE:

Weekly benefits for incapacity (limited to 70% of lost earning capacity after 6 months), costs of medical treatment, reasonable rehabilitation costs, benefits for permanent impairment, and death benefits. "

SCHEDULE 2

Regulation 3(b)

"FORM 6

Regulation 16

PAYMENT DECLARATION

WORK HEALTH ACT

INSURER

EMPLOYER DETAILS

NAME : ....

POSTAL ADDRESS : ....POSTCODE ....

OFFICE ADDRESS : .... POSTCODE ....

TELEPHONE NUMBER : ....

POLICY NUMBER : .... EXPIRY DATE : ...../...../.....

INSTRUCTIONS, please read.

The renewal advice to which this Declaration is attached shows details of your policy which will soon become due for renewal. To enable calculation of renewal premium payable for this coming year together with any adjustments due on last year's premium complete Declaration. This form is required by section 130 of the Work Health Act. It should be completed and given to your insurer within 28 days of the insurance policy's expiry date.

Please complete all sections of this form. If a section is not applicable please write "not applicable".

If there is insufficient room in the space provided, please attach a supplementary sheet.

NOTES

GROSS PAYMENTS INCLUDE :

A For Wage and Salary Earners, Family Members and Company Directors

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

(ii) Overtime

B For Other Persons or Contractors

(i) All payments made including payments for labour, materials, hire of tools, equipment and the like

Signature of person making declaration

The form is a statutory declaration and must be signed before a person who has 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.

Incorrect completion of this form could void your insurance policy and make you responsible for payment of any workers compensation claims plus other penalties.

Please contact the Work Health Authority or your Insurer for further information

I, (1) ....

do solemnly and sincerely declare as follows (2)

(1) Name & address of person making declaration

(2) Complete details of this form

(FORM 6 - continued)

SECTION A WAGES OR SALARIED WORKERS

Please complete this section for all persons who were paid wages or salary. IF THE BUSINESS IS A REGISTERED COMPANY do not include company directors in this section. IF THE BUSINESS IS NOT A REGISTERED COMPANY do not include immediate family members in this section. Include here any payments made to Exemption certificate holders where PAYE Tax was deducted. For other payments made to exemption certificate holders refer to Section E.

ACTUAL AMOUNTS PAID IN PREVIOUS PERIOD			ESTIMATE OF PAYMENTS FOR FUTURE PERIOD		
OCCUPATION	NO. OF EMPLOYEES	GROSS AMOUNT PAID	OCCUPATION	NO. OF EMPLOYEES	ESTIMATED FUTURE PAYMENTS

SECTION B IMMEDIATE FAMILY MEMBERS

Complete Column 1 for all members who are already endorsed or covered on the current policy. Complete Column 2 for those family members who are to be covered in the next period.

COLUMN 1 ACTUAL AMOUNTS PAID IN PREVIOUS PERIOD				COLUMN 2 ESTIMATE OF PAYMENTS FOR FUTURE PERIOD			
NAME OF MEMBER	RELATIONSHIP TO EMPLOYER	OCCUPATION	GROSS PAYMENTS	NAME OF MEMBER	RELATIONSHIP TO EMPLOYER	OCCUPATION	GROSS PAYMENTS

SECTION C COMPANY DIRECTORS

Complete Column 1 for all directors who are already endorsed or covered on the current policy. Complete Column 2 for those directors who are to be covered in the next period.

COLUMN 1 ACTUAL AMOUNTS PAID IN PREVIOUS PERIOD			COLUMN 2 ESTIMATE OF PAYMENTS FOR FUTURE PERIOD		
NAME OF DIRECTOR	OCCUPATION	GROSS PAYMENTS	NAME OF DIRECTOR	OCCUPATION	GROSS PAYMENTS

(FORM 6 - continued)

SECTION D OTHER WORKERS / CONTRACTORS

Complete this section for all natural persons and subcontractors who are not included in Section A B or C and are not holders of Exemption certificates.
Do not include registered companies, or persons who in the performance of a contract employed other workers.

ACTUAL AMOUNTS PAID IN PREVIOUS PERIOD					ESTIMATE OF PAYMENTS FOR FUTURE PERIOD				
NAME OF PERSON	OCCUPATION	TOTAL AMOUNT	VALUE OF MATERIALS AND PLANT	VALUE OF LABOUR	NAME OF PERSON	OCCUPATION	TOTAL AMOUNT	VALUE OF MATERIALS AND PLANT	VALUE OF LABOUR

SECTION E EXEMPTION CERTIFICATE HOLDERS

Complete this section only for payments to certificate holders in previous period which were made outside the certificate's validity (e.g. payments prior to the commencement of the certificate or subsequent to the expiry of the certificate). Do not include any payments made to certificate holders where PAYE tax was deducted (these payments should be included in Section A).

ACTUAL AMOUNT PAID					
NAME OF PERSON	OCCUPATION	TOTAL AMOUNT	VALUE OF MATERIALS AND PLANT	VALUE OF LABOUR	EXEMPTION CERTIFICATE NUMBER

Declared at .... the .... day of .... 19...... ....

(3) ....

Before me (4) ....

(5) ....

NOTE: A person wilfully making a false statement in a statutory declaration is liable to substantial penalties.

3. Signature of person making the declaration
4. Signature of person before whom the declaration is made
5. Name and contact address or telephone number of person before whom the declaration is made legibly written, typed or stamped.

(FORM 6 - continued)

PREMIUM CALCULATION

(FOR OFFICE USE ONLY)

NAME : ....

POSTAL ADDRESS : ....

INSURER :..EXPIRY DATE : ..../......./....... POSTCODE :............................

POLICY NUMBER : ....

PAST PERIOD FROM : TO :

SECTION	OCCUPATION	STAT. NUMBER	NO. OF EMPLOYEES	ACTUAL PAYMENTS	RATE %	GROSS PREMIUM

FUTURE PERIOD FROM : TO :

SECTION	OCCUPATION	STAT. NUMBER	NO. OF EMPLOYEES	ACTUAL PAYMENTS	RATE %	GROSS PREMIUM

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