NORTHERN TERRITORY OF AUSTRALIA

Regulations 1986, No. 49*

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 this 19th day of December, 1986.

E. E. JOHNSTON

Administrator

By His Honour's Command

S. P. HATTON

Chief Minister

WORK HEALTH REGULATIONS

1. CITATION

These Regulations may be cited as the Work Health Regulations.

2. COMMENCEMENT

These Regulations shall come into operation on 1 January 1987.

3. FORMS

A reference in these Regulations to a form by number is a reference to the form so numbered in the Schedule.

* Notified in the *Northern Territory Government Gazette* on 23rd December 1986.

G. L. DUFFIELD, Government Printer of the Northern Territory

4. MAXIMUM RATES OF EARNING FOR PURPOSE OF DEFINITION OF "WORKER"

(1) For the purposes of paragraph (f) of the definition of "worker" in section 3(1) of the Act, the prescribed amount is 13% of the annual equivalent of average weekly earnings.

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

5. EXEMPTION CERTIFICATE

Form 1 is the prescribed form for the purposes of section 58(2) of the Act.

6. FUNERAL BENEFIT AND APPLICATION FOR DETERMINATION OF ENTITLEMENT TO AN AMOUNT OF DEATH BENEFIT

(1) For the purposes of section 62(1)(a)(ii) of the Act, the prescribed amount is 10% of the annual equivalent of average weekly earnings.

(2) The relevant Form 2 is the prescribed form for the purposes of section 62(2) of the Act.

7. MINIMUM RATE OF COMPENSATION - LONG-TERM INCAPACITY

For the purposes of section 65(7) of the Act, the minimum rate of compensation under section 65 is the relevant rate of compensation that would have been payable in accordance with Schedule 2 of the *Workers' Compensation Act* as in force immediately before the commencement of Part V of the *Work Health Act* had the *Workers' Compensation Act* not been repealed, and the prescribed period is 12 months from and including 1 January 1987.

8. COMPENSATION FOR CERTAIN VOLUNTEERS

For the purposes of section 66 of the Act, compensation shall be calculated as the remuneration for the person's normal weekly number of hours of work for all employment of the person at the time of the injury calculated at his ordinary time rate of pay or 50% of average weekly earnings, whichever is the greater amount.

9. GUIDES TO EVALUATION OF PERMANENT IMPAIRMENT

(1) For the purposes of the definition of "permanent impairment" in section 70 of the Act, the American Medical Association Guides to the Evaluation of Permanent Impairment (2nd edition) are the prescribed guides.

(2) The Authority shall keep at its office in Darwin a copy of the prescribed guides and allow any person, during the normal business hours of the office, to examine the copy at its office.

10. CLAIMS

Form 3 is the prescribed form for the purposes of section 82(1)(a).

11. DECLARATIONS

Declarations required or permitted by or under the Act to be made may be made before -

(a) a person before whom a statutory declaration under the *Oaths Act* may be made;

(b) a postmaster or person in charge of a post office;

(c) a school headteacher;

(d) a medical practitioner; or

(e) a minister of religion.

12. MEDICAL CERTIFICATE TO ACCOMPANY CLAIM

(1) Form 4 is the prescribed certificate for the purposes of section 82(1)(b) of the Act.

(2) Subject to subregulation (3), a certificate referred to in subregulation (1) shall be signed by a medical practitioner.

(3) Where because of isolation a medical practitioner is not reasonably available to sign a certificate referred to in subsection (1), a practitioner registered under the *Health Practitioners and Allied Professionals Registration Act* in the category of Aboriginal health work or a nurse, within the meaning of the *Nursing Act*, may sign the certificate.

(4) A certificate signed in pursuance of subregulation (3) has effect only in respect of -

(a) where the certificate is signed after consultation by radio, telephone or other means with a medical practitioner - 14 days; and

(b) in any other case - 3 days.

13. STATEMENT OF RIGHT TO COMMENCE PROCEEDINGS BEFORE COURT

Form 5 is the prescribed form for the purposes of sections 69(d) and 85(10) of the Act.

14. LATE PAYMENT OF WEEKLY PAYMENTS

For the purposes of the formula in section 89 of the Act, 20% is the prescribed rate of interest.

15. PRESCRIBED INDEMNITY

For the purposes of section 126(1) of the Act, $2,000,000 is the prescribed amount.

16. EMPLOYER'S WAGES DECLARATIONS AND VERIFICATION

(1) Form 6 is the form in which statements referred to in section 130(1) shall be supplied.

(2) For the purposes of section 130(4)(b) of the Act, a statement shall be verified, where an employer is -

(a) an individual natural person - by the person;

(b) a partnership - by one of the partners;

(c) a body corporate (other than an incorporated association referred to in paragraph (c)) - by a director or secretary of the body corporate or its principal officer in the Territory; or

(d) an incorporated association, within the meaning of the *Associations Incorporation Act* - by the public officer,

making a statutory declaration to the effect that the estimate of wages and other prescribed information is true and correct.

17. ELECTION TO PAY PREMIUM BY INSTALMENT

For the purposes of section 131 of the Act, where an employer and insurer do not agree on the manner of election to pay premiums by instalments, the employer may elect by serving a notice in writing in accordance with Form 7 on the insurer not later than 21 days before the first instalment is payable under that section.

18. SERVICE ON NOMINAL INSURER

Anything required or permitted by the Act to be served or the Nominal Insurer may be served -

(a) by clearly marking it for the attention of the Nominal Insurer and leaving it, during normal business hours, at the Darwin office of the Authority with a person who has apparently attained the age of 16 years and is employed at that office; or

(b) by properly addressing and posting it by prepaid post to the Nominal Insurer, G.P.O. Box 2056, Darwin, N.T. 5794.

SCHEDULE

FORM 1

Regulation 5

(obverse side)

Work Health

CERTIFICATE OF EXEMPTION FOR INDEPENDENT CONTRACTORS FROM WORKERS COMPENSATION

SECTION 58 OF THE *WORK HEALTH ACT 1986*

CERTIFICATE NUMBER: ....

NAME OF CERTIFICATE HOLDER: ....

ADDRESS: ....

....

DATE OF COMMENCEMENT: ....

DATE OF EXPIRY: ....

NATURE OF BUSINESS: ....

This is to certify that the abovenamed is in business on his/her own account and is therefore an independent contractor for the purposes of the *Work Health Act* in respect of activities carried out for the purposes of that business.

CONDITIONS: ....

....

....

Signature of Certificate Holder: ....

FOR AND ON BEHALF OF THE WORK HEALTH AUTHORITY: ....

....

DATE OF ISSUE: ....

FORM 1

(Reverse side)

NOTES

1. Your certificate is granted by the Authority on the basis of information supplied in your application. It means that the Authority is satisfied that you are in business on your own account.

2. The certificate is valid whilst you are in business on your own account. If for any reason you cease to be in business on your own acount this exemption may not apply. This would be particularly so if you receive wages from which PAYE taxation is deducted.

3. Condition 2 of the certificate provides that any significant changes in your contract or employment arrangements must be notified to the Authority within 48 hours of those changes occurring.

4. This certficate may be revoked by the Authority at any time. You may hand in your certifcate for revocation at any time.

DECLARATION

I, (name) .... agree and understand that :

(i) I or my dependants are not entitled to any benefits or compensation as provided for workers under the Work Health Act.

(ii) I must comply with any conditions appearing on the certificate and that I could be liable for a fine of up to $ 1,000 for breach of those conditions.

(iii) The certificate does not exempt me from my responsibilities as an employer under the Act, which includes the responsibility to insure workers in my employment.

(iv) I have read and I understand the notes above.

____________________ (certificate holder) __________ (date) ____________________ (location)

FORM 2

Regulation 6(2)

WORKERS COMPENSATION CLAIM FORM IN THE CASE OF DEATH

To the person filling in this form

- Fill in this form if you were dependent on someone who died following a work related injury or disease.
- When you have filled in this form give it to the deceased's employer immediately
- Keep the Blue copy of the form for your records
- You can also get help and more information from the Work Health Authority Enterprise House, Cnr Knuckey and Woods Street Darwin (089) 81 1588
- For people outside Darwin ring 008 019115 for the cost of a local call

Insurer Stamp

Claim number

Workers' Compensation Claim

About the deceased

1 Name Surname or family name

First or given names

2 Sex Male ☐ Female ☐

3 Home Address

Postcode

4 Date of birth / /

5 Date of death / /

6 Occupation at the time of injury or disease which led to death. Include here the main job that was done

7 Employers business name, address and telephone number

Postcode

Telephone

8 Where did the deceased normally work?
SEE NOTE 1 ON THE BACK

Postcode

About the claim

9 Did the death follow a work related disease?

No ☐ Go to Question 10 'About the injury'

Yes ☐ Go to Question 14 'About the disease'

About the injury

10 Where did the injury happen?

A ☐ While working at usual workplace

B ☐ While working elsewhere

C ☐ While having a break

D ☐ Travelling to and from work

☐ Other **SEE NOTE 2 ON THE BACK**

11 Tell us the exact location or address where the injury happened?

Postcode

12 When did the injury happen?

Date / / Time am/pm

13 Please tell us:

- about all the events which led to the injury
- what the deceased was doing at the time
- how the injury happened

Now go to Question 16

About the disease

14 What date was the disease first noticed? / /

15 Please tell us:

- about all the events which led to the disease
- the address where the disease was contracted
- the main cause (for example — exposure to asbestos dust)
- the names of other employers the deceased worked for where the same sort of job was done

Witnesses

16 Did anyone see what happened?

No ☐ Yes ☐

Give the name and address of people who saw what happened

Postcode

Postcode

17 Was the injury or disease reported to the employer?

No ☐ Reason

Yes ☐

Date injury/disease was reported / /

Time injury/disease was reported am/pm

Name of the person reported to

Name

Position in the company

18 When did the deceased stop work because of the injury or disease?

Date stopped work / /

Time stopped work am/pm

19 Was the deceased off work for any period prior to death due to this injury or disease?

No ☐ Yes ☐ Period off work

/ / to / /

20 Did the deceased receive any compensation payments for this period?

No ☐ Yes ☐ Amount received $

Medical details

21 What was the cause of death include here:

- part of body affected
- type of injury or disease
- agency or thing that caused the injury or disease e.g. grinder, drill

MAKE SURE YOU ATTACH THE MEDICAL CERTIFICATE AND, IF POSSIBLE, THE DEATH CERTIFICATE TO THIS FORM.

22 Did the deceased get any medical treatment following the injury or disease?

No ☐ Yes ☐

Name and address of doctor and/or health worker

Postcode

Dates treated / / / /

23 Prior to death, was the worker admitted to a hospital/medical centre?

No ☐ Yes ☐

Give name and address of hospital/medical centre

Postcode

Period of time in hospital/medical centre

/ / to / /

/ / to / /

24 Has the deceased suffered from a similar injury or disease before?

No ☐ Yes ☐

Name of the doctor who treated the deceased

Address of the doctor

Type of injury or disease

When did injury or disease occur?

25 Have there been any claims for workers compensation before?

No ☐ Yes ☐ **SEE NOTE 3 ON THE BACK**

Name of employer

Include address

Type of injury or disease

When did injury or disease occur? / /

How long was the deceased off work?

Amount of compensation received $

Now go to Question 26 'About the dependants'

NOTES ON CLAIM FORM

NOTE 1.

Your answer here must tell us the actual address or location of the place where the deceased did the majority of his or her work.

NOTE 2.

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

NOTE 3

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

NOTE 4.

DEFINITION OF DEPENDANT

Dependants of a deceased worker are basically the family and spouse of that worker who are partly or wholly dependant on the worker's earnings at the date of the worker's death.

A spouse is the husband or wife of the deceased worker.
'Spouse' also includes defacto partners, and if the person is an aboriginal native, can include a partner according to the customs of the deceased worker's tribe or group.

'Family' can include any children or grandchildren of the deceased worker. This includes children born out of wedlock, and children who are not the deceased worker's natural offspring, e.g. adopted children.

Similarly, 'family' can also include any parent or grandparent of the deceased worker even though the deceased worker was born out of wedlock or was not the parent's natural offspring.

If the person is an aboriginal native, family can include all persons who are members of the deceased worker's family according to customs of the deceased worker' tribe or group.

About the deceased workers' dependants

26 Please give the following details about all the dependants of the deceased worker.
If there is not enough space, write the extra details on a separate piece of paper and pin it to this form
You must SEE NOTE 4 on the back to find out what dependant means.

1 Name Surname or family name

First or given names

Home address of this dependant

Relationship to deceased (wife, husband, son, daughter, etc.)

Date of birth of this dependant / /

Is this dependant a student?

No ☐ Yes ☐

Full time ☐ Part time ☐

Gross weekly income of this dependant
If none, write 'NONE' $

2 Name Surname or family name

First or given names

Home address of this dependant

Relationship to deceased (wife, husband, son, daughter, etc)

Date of birth of this dependant / /

Is this dependant a student?

No ☐ Yes ☐

Full time ☐ Part time ☐

Gross weekly income of this dependant
If none, write 'NONE' $

3. Name Surname or family name

First or given names

Home address of this dependant

Relationship to deceased (wife, husband, son, daughter, etc.)

Date of birth of this dependant / /

Is this dependant a student?

No ☐ Yes ☐

Full time ☐ Part time ☐

Gross weekly income of this dependant
In none, write 'NONE' $

4 Name Surname or family name

First or given names

Home address of this dependant

Relationship to deceased (wife, husband, son, daughter, etc.)

Date of birth of this dependant / /

Is this dependant a student?

No ☐ Yes ☐

Full time ☐ Part time ☐

Gross weekly income of this dependant
If none, write 'NONE' $

Declaration

27 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 relating to the work related injury or disease which led to the death of the worker.

Signature

Date / /

Name, address and relationship to the deceased of the person completing this form

FORM 2

Regulation 6(2)

EMPLOYERS' REPORT FOLLOWING A WORKERS COMPENSATION CLAIM IN THE CASE OF DEATH

To the employer

- Fill in this claim form if you have received a workers compensation claim following the death of a worker
- Send the Red and Green copies of this report together with the Red and Green copies of the claim form to the insurance company immediately
- Keep the Yellow copies of this report and the claim form for your records
- You can also get help and more information from the Work Health Authority Enterprise House, Cnr Knuckey and Woods Street Darwin (089) 81 1588
- For people outside Darwin ring 008 019115 for the cost of a local call

Insurer Stamp

Claim Number

Employer details

1 Business name, address for correspondence and phone number?

Postcode

Telephone

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

Name:

Position in the company

Insurance details

3 What is your insurer's name?

4 What is the policy number?

What is the expiry date of this policy? / /

About the deceased worker

6 Workers name

Surname or family name

First or given names

7 Sex Male ☐ female ☐

8 Home address

Postcode

9 Date of birth / /

10 Where did the worker normally work **SEE NOTE 1 ON THE BACK**

Postcode

11 How many people are employed at this location?

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

13 How many hours did the worker normally work each week Do not include overtime **SEE NOTE 2 ON THE BACK** hours

14 What was the worker's gross weekly wage? Do not include overtime $

15 What was the workers award rate? $

16 When did the worker stop work following the injury or disease which led to death? / / am pm

17 Occupation at the time of injury or death? Include also the main job that was done

18 In what type of industry was the worker employed? **SEE NOTE 3 ON THE BACK**

About the incident

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

NO ☐ YES ☐

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

20 Did the incident happen

— on a mine site NO ☐ YES ☐

— on a construction site NO ☐ YES ☐

21 Did the incident involve.

— licensed machinery NO ☐ YES ☐

SEE NOTE 4 ON THE BACK

— dangerous goods NO ☐ YES ☐

SEE NOTE 5 ON THE BACK

— electric shock NO ☐ YES ☐

About this claim

22 Is this claim about a death related to disease?

NO Go to question 23 'About the deceased workers injury'

YES Go to question 26 'About the deceased workers disease'

About the deceased workers injury

23 Where did the injury happen?

A ☐ While working at usual workplace
C ☐ While having a break
B ☐ While working elsewhere
D ☐ Travelling to and from work
☐ Other **SEE NOTE 6 ON THE BACK**

24 Tell us the exact location or address where the injury happened?

Postcode

25 When did the injury happen?

Date / / Time am/pm

26 Please tell us:

- about all the events which led to the injury
- what the worker was doing at the time
- how the injury happened

Now go to Question 28

About the workers' disease

27 Is this report about a work related disease which led to death?

No ☐
Yes ☐

Please describe the events which led to the disease and subsequent death including the address where it happened and the main cause

Witnesses

28 Did anyone see what happened to the worker?

No ☐ Yes ☐

Give the name and address of people who saw what happened

Postcode

Postcode

29 Was the injury reported to you or a member of your staff?

No ☐ Reason

Yes ☐

Date injury/disease was reported / /

Time injury/disease was reported am/pm

Name of the person who received the report

Name

Position in the company

30 Has the deceased been off work for any period prior death due to this injury or disease?

No ☐ Yes ☐

Period off work

from / / to / /

31 Did the deceased receive any compensation payments for this period?

No ☐ Yes ☐

Amount received $

Declaration

27 I declare that all 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 the workers' injury or disease which led to death.

SIGNATURE

DATE / /

Name of the person who filled in this form

Name

Position in the company

NOTES ON CLAIM FORM

NOTE 1.

Your answer here must tell us the actual address of the place where the deceased did the majority of his or her work.

NOTE 2.

In the case of a deceased who was 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 deceased 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 death.

NOTE 3.

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

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

NOTE 4.

'Licensed machinery' means any piece of machinery licensed by the Industrial Safety Division of the Department of Mines and Energy under the Inspection of Machinery Act.

NOTE 5.

'Dangerous Goods' means any substance which is defined as dangerous by the Dangerous Goods Act administered by the Industrial Safety Division, Department of Mines and Energy.

NOTE 6.

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

FORM 3

Regulation 10

WORKERS COMPENSATION CLAIM FORM
and
EMPLOYERS' 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 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 Enterprise House, Cnr Knuckey and Woods Street Darwin (089) 81 1588
- For people outside Darwin ring 008 019115 for the cost of a local call

To the Employer

- Make sure a separate form is filled in for each injured or ill worker
- **Send the Red and Green 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 workers' medical certificate is 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 Enterprise House, Cnr Knuckey and Woods Street Darwin (089) 81 1588
- For people outside Darwin ring 008 019115 for the cost of a local phone call
- If a worker has died, do not fill in this form, please contact the Work Health Authority

Insurer Stamp

Claim number

Workers' Compensation Claim

About You

1 Name 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

7 Are you A ☐ an apprentice?

T ☐ a trainee under the Australian traineeship system?

8 How many hours do you normally work each week? Do not include overtime **SEE NOTE 1 ON THE BACK** hours

9 What was your gross weekly wage before your injury or disease? Do not include overtime $

About your claim

10 Is your claim about a work related disease?

No ☐ Go to Question 11 'About your injury'

Yes ☐ Go to Question 15 'About your disease'

About the injury

11 Where did your injury happen?

A ☐ While I was working at usual workplace

C ☐ While I was having a break

B ☐ While I was working elsewhere

D ☐ Travelling to and from work

☐ Other **SEE NOTE 2 ON THE BACK**

12 Tell us the exact location or address where your injury happened?

Postcode

13 When did your injury happen?

Date / / Time am/pm

14 Please tell us:

- about all the events which led to the injury
- what you were doing at the time
- how the injury happened

Now go to Question 17

About your disease

15 What date did you first notice your disease? / /

16 Please tell us:

- about all the events which led to your disease
- the address where the disease was contracted
- the main cause (for example — exposure to asbestos dust)
- the names of other employers you worked for where you did the same sort of job

Witnesses

17 Did anyone see what happened to you?

No [ ] Yes [ ]

Give the name and address of people who saw what happened to you

Postcode

Postcode

18 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

19 Did you stop work because of your injury or disease?

No [ ] Yes [ ]

Date you stopped work / /

Time you stopped work am/pm

20 Have you started back at work?

No [ ] Yes [ ]

SEE NOTE 3 ON THE BACK

Date you started back / /

Time you started back am/pm

About your Condition

21 Include here:
- part of body affected
- type of injury or disease
- agency or thing that caused the injury or disease e.g. grinder, drill

You must attach your medical certificate on this form

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

[ ] [ ]

Name and address of the doctor and/or health worker

Postcode

Dates you were treated / / / /

23 Were you admitted to a hospital/medical centre?

No [ ] Yes [ ]

Give name and address of hospital/medical centre

Postcode

Period of time you were in hospital/medical centre

/ / to / /

/ / to / /

24 Are you still receiving treatment?

No [ ] Yes [ ] Name of the person treating you

25 Have you suffered from 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 injury or disease occur?

26 Have you claimed workers compensation before?

No [ ] Yes [ ]

SEE NOTE 4 ON THE BACK

Name of employer

Include address

Type of injury or disease

When did injury or disease occur? / /

How long were you off work?

Amount of compensation paid to you $

Declaration

27 I declare that all 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/the work related injury or disease

SIGNATURE

DATE / /

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

Postcode

NOTES ON CLAIM FORM

FOR THE WORKER

NOTE 1.

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 the injury.

NOTE 2.

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

NOTE 3.

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 4.

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

FOR THE EMPLOYER

NOTE 5.

Your answer here must tell us the actual address of the place where the worker does the majority of his or her work.

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.

'Licenced machinery' means any piece of machinery licensed by the Industrial Safety Division of the Department of Mines and Energy under the Inspection of Machinery Act.

NOTE 8.

'Dangerous Goods' means any substance which is defined as dangerous by the Dangerous Goods Act administered by the Industrial Safety Division, Department of Mines and Energy.

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.

28 Business name, address for correspondence and phone number?

Postcode

Telephone

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

Name:

Position in the company

Insurance details

30 What is your Insurer's name?

31 What is the policy number?

32 What is the expiry date of the policy?

/ /

About the injured or diseased worker

33 Where does the worker normally work? **SEE NOTE 5 ON THE BACK**

Postcode

34 How many people are employed at this location?

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

36 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

37 In what type of industry is the worker employed?
SEE NOTE 6 ON THE BACK

More than one person Injured

38 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

39 Did the incident happen:

— on a mine site NO ☐ YES ☐

— on a construction site NO ☐ YES ☐

40 Did the incident involve:

— licensed machinery NO ☐ YES ☐
SEE NOTE 7 ON THE BACK

— dangerous goods NO ☐ YES ☐
SEE NOTE 8 ON THE BACK

— electric shock NO ☐ YES ☐

Declaration

41 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 workers' injury or disease

SIGNATURE

DATE / /

Name of the person who has filled in this form

Position in the company

FORM 4

Regulation 12(1)

Work Health

Medical Certificate for Workers Compensation

Practice/Hospital/Health Centre

....

....

I have examined

In my opinion this person is suffering / has suffered from

Please give a precise diagnosis

and is unfit for work from / / to / / *inclusive*

The illness or injury was stated to be caused by

....

Is the incapacity likely to last more than 6 weeks?

No ☐ Yes ☐

Is it likely that rehabilitation will be required?

No ☐ Yes ☐

- ☐ Physiotherapy
- ☐ Occupational therapy
- ☐ Other — please specify

Signature

Name and date / /
please print

FORM 5

Regulation 13

WORK HEALTH

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

Dear ....

Pursuant to your claim for payment of benefits as prescribed in 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 67 of the Work Health Act.
Varies the amount of weekly benefits payable to you pursuant to Section 67 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.

If your claim is disputed pursuant to Section 85, you must make an application to the Work Health 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 28 days of the date of filing) for hearing of your application at a preliminary conference.

If you have any further queries about your rights under Work Health, Please contact the Work Health Authority, Enterprise House, Cnr. Knuckey & Woods St., Darwin N.T 5790 or GPO box 2010, Darwin NT 5794. Phone (089) 811 588. Toll Free outside Darwin (008) 019 115

FORM 6

Regulation 16

PAYMENT DECLARATION

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 pays 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

This form is a statutory declaration and must be signed before a Justice of the Peace, or a Commissioner for Oaths. 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

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

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 currency (i e. 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

I, (1) ....

Do solemnly and sincerely declare by virtue of the Oaths Act and conscientiously believing the statements contained in this declaration to be true in every particular.

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

(2) ....

Before me (3) .... (4) ....

NOTE: A person wilfully making a false statement in the statutory declaration liable to a penalty of $1000 or imprisonment for 6 months or both

1. Name and address of person making declaration
2. Signature of person making the declaration
3. Signature of person before whom the declaration is made
4. Title of person before whom the declaration is made

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