

3. Please complete the following table with full details of any payments being received by this employee, or that they are entitled to receive, since the date last worked. This includes, but is not limited to, Social Security/Centrelink, Worker's Compensation/Common Law/CTP or other forms of insurance, or any other source of payments. If more space is required, please complete a separate sheet of paper and attach it to this form.

Source of payments (e.g. insurer name) and claim no.	Contact person	Address	Phone no.	Date claim commenced	Date payments commenced	Gross weekly amount received
1.				DD/MM/YYYY	DD/MM/YYYY	
2.				DD/MM/YYYY	DD/MM/YYYY	
3.				DD/MM/YYYY	DD/MM/YYYY	
4.				DD/MM/YYYY	DD/MM/YYYY	
5.				DD/MM/YYYY	DD/MM/YYYY	
6.				DD/MM/YYYY	DD/MM/YYYY	

4. Was the employee: Full-time Part-time Casual

5. What were the average hours worked per week? Hours per week

6. What hours did the employee work in their usual job? Start Finish

7. Please describe the normal duties the employee performed on a daily basis and % of time spent performing each duty. Please attach the employee's job description.

8. Please describe the duties the employee performs on a daily basis necessary to produce income.

9. Please indicate the following requirements of the employee's job. **A = 0%, B = less than 25%, C = more than 25%, D = continuous**

	A	B	C	D	Estimate - total to be less than or equal to 100%	
Lifting, 23 kgs and over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting <input type="text"/> <input type="text"/> <input type="text"/> % of the day	Crawling <input type="text"/> <input type="text"/> <input type="text"/> % of the day
Lifting, 9 to 22 kgs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Walking <input type="text"/> <input type="text"/> <input type="text"/> % of the day	Bending <input type="text"/> <input type="text"/> <input type="text"/> % of the day
Lifting, under 9 kgs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Standing <input type="text"/> <input type="text"/> <input type="text"/> % of the day	Crawling <input type="text"/> <input type="text"/> <input type="text"/> % of the day
Carrying to <input type="text"/> <input type="text"/> <input type="text"/> kgs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Driving <input type="text"/> <input type="text"/> <input type="text"/> % of the day	Climbing <input type="text"/> <input type="text"/> <input type="text"/> % of the day (ladders, ramps, steps, etc.)
Reaching above shoulders <input type="text"/> <input type="text"/> <input type="text"/> kgs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kneeling <input type="text"/> <input type="text"/> <input type="text"/> % of the day	

10. Was the employee performing the normal duties of their occupation on the last day of active work? Yes No
 If **no**, what were the duties on the last day of work? If the information does not fit in the space provided, please attach a separate page to this form.

11. Please detail the education, training or experience required to perform the job.

12. Please provide a full description of any previous positions the employee has undertaken whilst employed by your organisation and include time spent in each job.

13. Did the employee have any performance issues? Please provide details.

14. Did the employee's duties allow them to move freely during work hours or were they generally confined to a set space or position?

15. Dates of continuous total disablement due to this current condition

i.e. not working in any capacity. From To

If the employee has been on and off work, please attach a list of the applicable dates or their leave history (including all leave such as sick, annual and long service leave) for 12 months prior to ceasing work and confirm whether they returned in a part or full time capacity.

16. Is the employee's job still available? Yes No

17. Do you have any alternate jobs appropriate to the employee's level of skill or experience? Yes No

18. Have any alternate jobs been offered to the employee? Yes No

If **yes**, please provide details.

19. If the employee is medically certified fit, are you able to provide a:

Return to part-time work Return to suitable duties Return to full-time work

20. In the event of a return to work, do you have a preferred rehabilitation provider you would like OnePath to liaise with? Yes No

If **yes**, please provide details.

21. If the employee has already returned to work on a full-time, part-time or restricted duties basis, please confirm:

a). Date of return to full-time work b). Date of return to part-time work

c). Number of hours/week they returned to d). Hourly rate \$

e). Please confirm the duties the employee is currently performing.

f). Please confirm the duties the employee is currently unable to perform.

22. If a rehabilitation assessment/return to work plan has commenced, please complete the following table.

Rehabilitation provider	Contact person	Address	Phone no.	Date rehabilitation commenced	Has a return to work plan been completed/commenced?
1.				DD/MM/YYYY	
2.				DD/MM/YYYY	
3.				DD/MM/YYYY	

23. Please advise the current status of rehabilitation and forward copies of all rehabilitation reports/return to work plans.

Two empty rectangular text boxes for providing rehabilitation status and reports.

24. Any further comments you wish to make in relation to this claim.

A series of 15 empty rectangular text boxes for providing further comments on the claim.

Please attach the following with your completed form. Please tick the box to confirm the attachments.

- Job description(s)
- Rehabilitation reports and plans
- Leave reports
- Termination documents
- Copy of employee's resume
- Any other information that will assist in the assessment of the employee's claim.

I declare that the above details are true and correct

Your name

Your title/position

Signature Date

Phone Fax

Email

Please ensure this form is fully completed. Failure to do so may result in the claim forms being returned and a delay in assessing the claim.