actlawsociety

Personal Injury Claim Notification

pursuant to the Civil Law (Wrongs) Amendment Regulation 2004

Complete the form in BLOCK LETTERS
Provide details on separate sheets if required

To Respondent

Address

Postcode

1: Your personal details

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Given name(s)

Surname

Date of birth

/ /

Home address

Postcode

Postal address or 'as above'

Postcode

Home phone number ( ) | Work phone number ( )

2: Have you even been known by another name?

No ☐
Yes ☐ Give details below

Surname

Given name(s)

3: Are you legally represented?

No ☐
Yes ☐ Give details in next column

Name of firm

Name of solicitor

Date you first consulted a solicitor

/ /

Date you first identified the respondent

/ /

4: Accident/Incident Details

How were you injured?

☐ Work-related accident — notice to a party other than employer
☐ Medical negligence
☐ Public liability
☐ Product liability
☐ Other — state type

Date of accident

/ /

Time of accident

am
pm

Place of accident (include street and town if applicable)

Postcode

Please provide a description of the accident

5: Do you know if police, ambulance, fire brigade or any other emergency service attended the accident?

No ☐
Yes ☐ Give details below

Name of service

Name of person who attended

Contact details

6: Do you know if any witness statements were taken (for example by police)?

No ☐
Yes ☐ Give details below

Witness 1

Surname

Given name(s)

Home address

Postcode

Home phone number ( )

Work phone number ( )

Witness 2

Surname

Given name(s)

Home address

Postcode

Home phone number ( )

Work phone number ( )

7: Have you issued a claim notification to any other entity?

No ☐
Yes ☐ Give details below

Claim notification issued to:

8: Are you receiving, or entitled to, any other forms of compensation as a result of this accident? (For example, workers compensation)

No ☐
Yes ☐ Give details below

Name of insurance company

Type of policy

Policy/Claim number

9: Have you lodged a claim?

No ☐
Yes ☐ Give details below

Date claim lodged

/ /

Claim number

10: Medical Details

What are your injuries from the accident? (list all injuries)

Did the accident cause any aggravation to any pre-existing condition/s?

No ☐
Yes ☐ Give details below

11: Did you go to hospital after the accident?

No ☐

Yes ☐ Give details below

Name of hospital

Date

/ /

12: Who has treated you for your injuries or any aggravated pre-existing conditions since the accident?

List all doctors, surgeons, physiotherapists, specialitists etc.
(Please include annexure if there is not enough room)

Name

Address (practice or surgery)

Postcode

Phone number

( )

What treatment or rehabilitation have you had?

13: Employment details

Have you lost income as a result of this accident?

No ☐

Yes ☐

13.2: Please advise your employment status

- ☐ Full time employed
- ☐ Part time employed
- ☐ Self employed
- ☐ Casual
- ☐ Retired
- ☐ Student/Child
- ☐ Home duties
- ☐ Not working
- ☐ Pension (please describe below)
- ☐ Other (please describe below)

Please provide your employment details:

Name of employer

Contact person's name

Contact phone number

( )

Workplace address

Postcode

Usual weekly working hours:

Ordinary

Overtime

Usual weekly earnings (include overtime, regular bonuses and commission):

Gross (before tax)

$

Net (after tax)

$

Description of duties:

Is the work you do or your weekly earnings different because of the accident?

No ☐

Yes ☐ Give details below

(If self employed) Have you lost income from self employment in your own business because of the accident?

No ☐

Yes ☐ Give details below

If self employed:

Name and nature of business

Accountant's name

Accountant's contact details

Postcode

Phone number

(   )

Estimate of earning loss (if known, give details of how much you believe you have lost and how you calculated the amount. You must be able to give copies of your taxation returns, group certificates and assessment notices).

$

14: Claim against health service providers

Is the claim against a health service provider? (eg a doctor)

No ☐

Yes ☐ If yes, what is the medical condition for which you sought treatment?

Is the claim related to a new injury or the worsening of a pre-existing injury?

New ☐

Pre-Existing ☐

What did the health service provider do or not do which caused the injury or worsened a pre-existing injury?

Do you believe the health service provider failed to inform you of the risks involved in the treatment you undertook?

No ☐

Yes ☐ If yes, please provide details as to when you believe the information should have or could have been provided to you.

Name of service provider

Date / /

Time am pm

Place

Did the health service provider provide any written or oral information or warning?

No ☐

Yes ☐ If yes, please provide details

Date / /

Time am pm

Place

Warning given

Did you consent to the treatment given to you by the health service provider which has given rise to the injury?

No ☐

Yes ☐

Was it written or oral consent?

Written ☐

Oral ☐

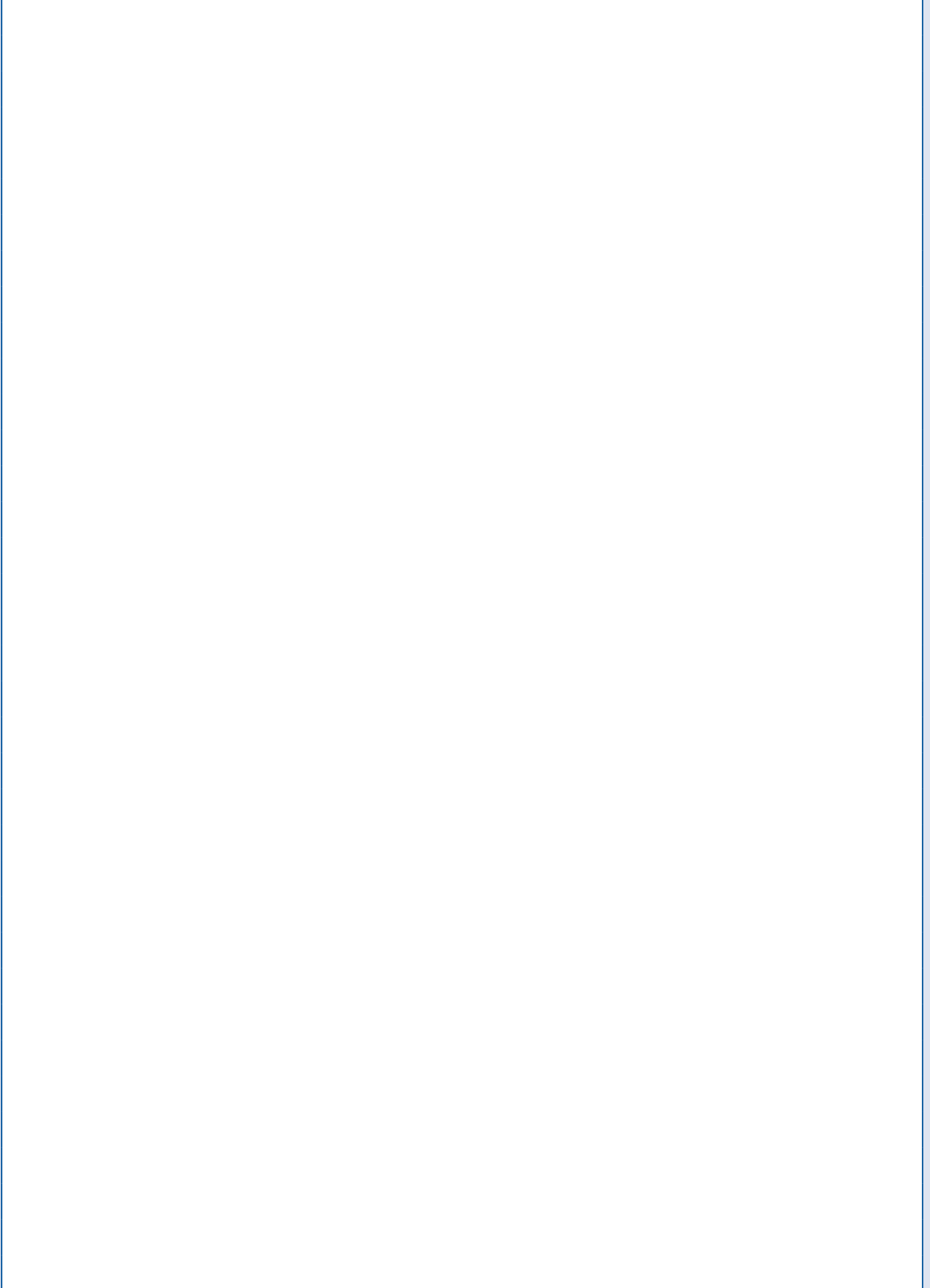
When and where was the consent given?

Place

Date / /

15. Diagram of Accident

Draw a diagram of the accident. Include all relevant details.



16. Authorisation

Given name(s)

Surname

Address

Postcode

authorise the respondent and the respondent's insurer for the claim (if any) to have access to the following records and sources of information relevant to the claim which occurred on:

1) Clinical notes in the possession of a health service provider who treated or assessed the injured person for the pre-existing injury or condition
2) Clinical notes in the possession of a hospital (including a private hospital) where the inured person received treatment relevant to the personal injury
3) Records in the possession of an ambulance or other emergency service that treated or assisted the injured person in relation to the personal injury
4) Clinical notes in the possession of a health service provider who treated or assessed the injured person in relation to the personal injury
5) Wage, leave and work history records in the possession of
   (i) the injured person's employer
   (ii) anyone else who employed the injured person at any time during the 3 years before the accident.

The respondent and the respondent's Insurer (if any) must not use records and sources of information accessed under sub regulation (1) otherwise than for a purpose related to the claim. The person must provide the injured person within one month with copies of any documents obtained pursuant to this authorisation.

Documents to accompany notice of claim

The notice of claim must be accompanied by the following documents:

a) for a claim other than a claim against a health service provider – a copy of any certificate signed by a doctor relevant to the personal injury to which the claim relates that is in the claimant's possession.
b) for a claim against a health service provider – a copy of any advice or warnings given to the injured person by the health service provider about the treatment claimed to have given rise to the personal injury that is in the claimant's possession.
c) for a claim against a health service provider – a copy of any consent given to the health service provider by the injured person about the treatment claimed to have given rise to the personal injury that is in the claimant's possession.
d) a copy of any other document on which the claimant currently expects to rely for the claim that is in the claimant's possession.

Signature of injured person

Date

/ /

*If another person signed on behalf of the injured person:

Given name(s)

Surname

Home phone number ( )

Work phone number ( )

Relationship to the injured person

Reason why the injured person could not sign