ACT Workers Compensation Review

Nomination for Individual Interview
(All information on this form will be treated as confidential)

Name: _____

Address: _____

Telephone Number: _____ (H) _____(W) _____(M)

Date of Injury: _____

Name of Employer at Time of Injury: _____

Name of Insurer (if known): _____

Claim Number (if known): _____

Nature of Injury:

_____

_____

_____

Outcome of Claim: _____

Summary of Comments to be expanded upon at Interview:

_____

_____

_____

_____

_____

_____

_____

Send form to:

Australian Health and Safety Services
PO Box 250
KIPPAX ACT 2615

Fax: (02) 6259 0134
Email: dsegrott@webone.com.au