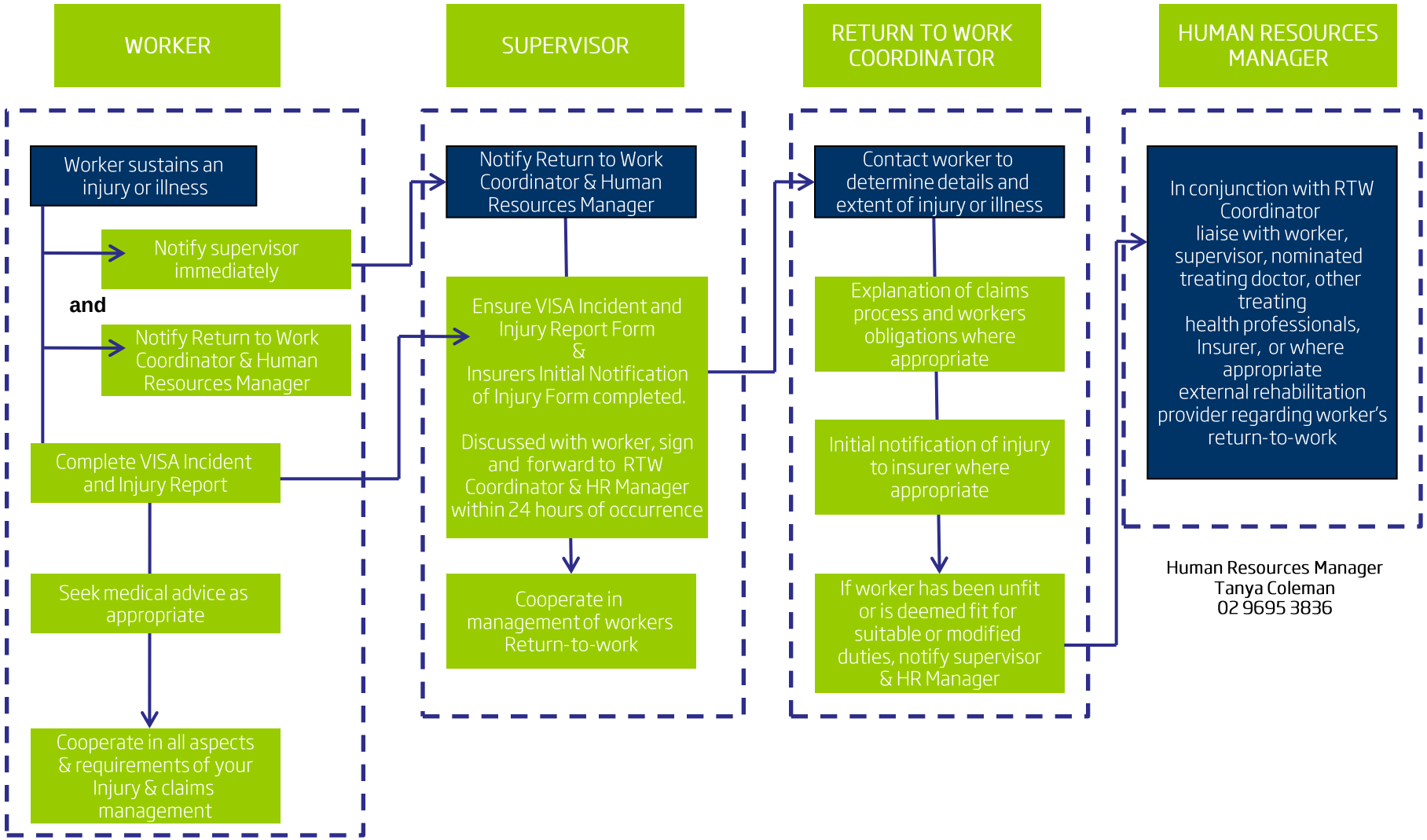
INJURY MANAGEMENT FLOWCHART FOR A WORK RELATED INJURY OR ILLNESS



Human Resources Manager
Tanya Coleman
02 9695 3836

24 HOUR TREATMENT OF WORKPLACE INJURIES – SYDNEY STAFF

24-HOUR TREATMENT OF WORKPLACE INJURIES

IMMEX GREEN SQUARE
INJURY MANAGEMENT & MEDICAL EXAMINATIONS

9319 5999

561 BOTANY ROAD
ALEXANDRIA

IN THE EVENT OF A WORKPLACE INJURY OR ACCIDENT

1. Immediately phone Immex Green Square on **9319 5999** to arrange an appointment or request treatment of injury ASAP.
2. Fax the referral form to **9319 5990** ASAP.

MAJOR INJURY THAT REQUIRES TRANSPORT TO HOSPITAL

- Unconscious or disoriented now or at any time
- Amputation of arm or leg
- Suspected poisoning
- Suspected heart attack
- Crushing chest pain
- Light-headed or feeling as if going to pass out
- Person looks pale, blue or sweaty
- Difficulty breathing
- Penetrating wounds to head, neck, thorax, abdomen, groin or eye
- Broken bones protruding through skin
- Suspected broken thigh or shinbone
- Dislocated shoulder
- Suspected neck or spine injuries
- Burns greater than specific size or to critical body parts (Doctor can advise more specifically)

ALL OTHER MEDICAL CIRCUMSTANCES SHOULD GO TO IMMEX GREEN SQUARE IMMEDIATELY

IMMEX
LEADERS IN OCCUPATIONAL HEALTHCARE

REFERRAL

TO BE COMPLETED BY EMPLOYER UPON REFERRAL
Phone IMMEX on 02 9319 5999 & Press 2 for an appointment or to advise if employee referral is URGENT.

EMPLOYEE / PERSON TO BE ASSESSED		
FIRST NAME:	SURNAME:	STAFF NO.
EMPLOYER'S NAME:		DEPOT:
OCCUPATION / JOB ROLE:		
DATE OF BIRTH:	PATIENT'S MOBILE PHONE:	

SERVICES REQUIRED
☐ PRE-PLACEMENT MEDICAL
☐ TREATMENT OF OCCUPATIONAL INJURY / ILLNESS
☐ TRANSPORT* One Way ☐ Round Trip ☐
TYPE OF INJURY / ILLNESS:
DATE OF INJURY:
APPOINTMENT DATE & TIME:
☐ URINE DRUG AND ALCOHOL SCREEN AS PART OF INJURY MANAGEMENT

BILLING DETAILS		
ENTITY RESPONSIBLE FOR PAYING THE ACCOUNT:		
PURCHASE ORDER NO.		
CONTACT PERSON:		
CONTACT'S POSITION:		
ADDRESS:		
PHONE:	FAX:	EMAIL:

REFERRER DETAILS		
BUSINESS NAME:		
CONTACT PERSON:		
CONTACT'S POSITION:		
ADDRESS:		
PHONE:	MOBILE:	EMAIL:

The business entity named above, agrees the charges associated with IMMEX Transport* and Professional Services are the responsibility of the business and will pay within 30 days of the date of invoice.

SIGNATURE: DATE:

Pre employment Medicals, Injury Management, IMC, IME, Fitness for Duty, Medico Legal, Physio

IMMEX Green Square Medical Treatment Pty Ltd ABN 98 106 382 781
561 Botany Road Waterloo NSW 2017
Phone 02 9319 5999 Fax 02 9319 5990 Email referral@immex.com.au Web www.immex.com.au

FLOWCHART FOR RETURN TO WORK COORDINATOR AND HUMAN RESOURCES

Received advice around an injury to a worker

NO

YES

Contact Supervisor

To confirm if incident/injury occurred.

If "yes" follow requirements

Minor Injury:
Should injury only require a doctors consultation and total costs will fall below Insurer excess (usually one week salary of injured employee) no claim for medical expenses or loss of wages via Insurer. Costs to be borne by company.

Major Injury:
Any injury that will result in loss of employee wages and require ongoing treatment must be advised to insurer wherein appropriate action and documentation will be required to cover loss of wages and pay appropriate medical treatment.

Received completed VISA Incident and Injury Report Form

Received completed Insurer Initial Notification of Injury Form

Received Workers Compensation Medical Certificate

Forms must be logged with Insurer within 24 hours of injury notification

Workers Compensation Case is not close until receipt of all appropriate W/Comp Medical Certificates:

1. Initial
2. Progress
3. Final

Each must be forwarded to insure and copy held on file

The WorkCover Medical Certificate

The WorkCover medical certificate is to be completed by the nominated treating doctor. The medical certificate is our most important communication tool. The WorkCover medical certificate provides crucial information to other parties and guides decisions about:

- accepting a workers compensation claim
- the type and amount of weekly benefits an injured worker will be paid
- the development of the injury management plan by the insurer
- the development of the return to work plan by the employer/return to work coordinator/workplace rehabilitation provider
- approving reasonably necessary treatment.

SAMPLE FORMS FOR WORKERS COMPENSATION – VISA GLOBAL INTERNAL FORM

Incident and Injury Report

Use this form to record all incidents, injuries or accidents, whether treatment is required or not.

Details of Incident (eg property, plant or environmental damage)

Date of incident _____ Time of incident _____ am pm

Nature of incident _____

Location of incident _____

Description of incident _____

Details of damage to Equipment or property: Yes / No

Name of person who Received the report _____ Telephone _____

Reported to authorities: Yes / No — Provide details (when & whom) _____

Details of Injury and/or Near Miss

Date of Injury _____ Time of Injury _____ am pm

Name of Injured person _____

Address _____

Date of Birth _____

Telephone Contact _____

Occupation _____

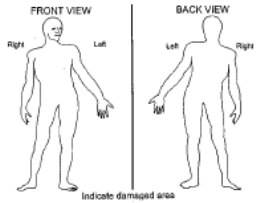
Activity in which the person was engaged at the time of the injury or near miss _____

Complete for Injuries only

Nature of injury – eg fracture, burn, sprain, foreign body in eye _____

Body location of injury

(indicate location of injury on the diagram)



Treatment given on site _____ Name of treating person _____

Did the injured worker stop work? Yes / No — If yes, date & time they stopped — Date: Time:

Referral for further treatment? Yes / No — Name of doctor or hospital _____ — Medical certificate received (attach copies) Yes / No

Injury management required? Yes / No — Notify return to work coordinator? Yes / No

Reported to authorities Yes / No — Provide details (when and whom) _____

Witness to incident/injury/near miss (each may need to provide an account of what happened)

Witness Name _____ Witness Contact _____

Witness Name _____ Witness Contact _____

Cause of incident/injury/near miss: _____

Preventative actions (include what needs to be done, who will do it and when will it be done: _____

Completed by:

Employee Signature: _____ Date: _____

Supervisor/Manager Signature: _____ Date: _____

HR Manager Signature: _____ Date: _____

SAMPLE FORMS FOR WORKERS COMPENSATION – QBE INITIAL NOTIFICATION OF INJURY: http://www.qbe.com.au/Australia/Useful-Resources/Claim-Forms/Insurance.html

QBE

QBE Workers Compensation (NSW) Limited
ABN 83 564 379 108 004
Agent for the NSW WorkCover Scheme

Claim or notification number, if known

Policy number, if known

WORKERS COMPENSATION ACT 1987

INITIAL NOTIFICATION OF INJURY

This form is to be used when a worker suffers a workplace injury or illness where workers compensation is or may be payable. Notify your Agent within 48 hours. Notify injuries without delay, even if all the information is not known.
Please complete this form in BLOCK letters and use a black pen.
Return completed form to QBE, refer to address details on the last page.

1 WORKER'S DETAILS

Family name

Given names

Date of birth D D / M M / Y Y

Sex: Male Female

Residential address
Street

Suburb

Postcode

Phone
Work ( ) Mobile Home ( )

2 EMPLOYER'S DETAILS

Company name

Location of business premises
Street

Suburb

Postcode

Name of workplace contact, if known (eg. name of return to work coordinator)

Phone ( )

NSW WorkCover

3 INJURY DETAILS

Description of incident (eg. slipped from a ladder while painting the ceiling)

Description of injury (eg. concussion and broken right arm)

Date of injury D D / M M / Y Y

Date Employer Notified D D / M M / Y Y

Has the injured worker returned to work?
Yes No Don't know

If Yes, state date returned D D / M M / Y Y

If No, estimate date of return D D / M M / Y Y

4 TREATING DOCTOR'S DETAILS

Doctor's name

Hospital name (if worker hospitalised)

Phone ( )

5 NOTIFIER'S DETAILS

Name

Relationship to worker or employer

Address
Street

Suburb

Postcode

Phone
Work ( ) Mobile Home ( )