




HR019	Injury / Illness Management Policy
Purpose	To ensure Free Reformed School Association (FRSA) staff are aware how to act when a work-related injury / illness occurs
Authority	Disability Discrimination Act 1992, Disability Services Act 1993 (WA)
Policy	FRSA Administration will provide case management for staff who are injured during work or a work-related illness.
Delegation	
Related Policies	HR004 Applicable Awards and Conditions of Employment Proc004 Occupational Safety & Health Proc005 Crisis Management
Date approved	May 2015; June 2018
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Review Authority	Management
Keywords	Injury, worker's compensation, return to work, medical certificate, fitness for work

Authorised by:	
ESG Chairman	D Swarts
Date:	June 2018



HRP019

Injury / Illness Management Procedure

BACKGROUND:

All employers must comply with the requirements of the Disability Discrimination Act 1992, Disability Services Act 1993 (WA), Equal Opportunity Act 1984 (WA).

All employees who are injured in the course of work may apply to receive workers' compensation benefits for a compensable injury, as defined in the Workers' Compensation and Injury Management Act 1981 (the Act) including a personal injury by accident arising out of or sustained during the course of his or her employments.

Claims that occur on the journey to or from work, and stress claims wholly or predominantly arising from the exclusion provisions in the Act including, but not limited to, an employee's dismissal, retrenchment, demotion, discipline, redeployment, failure to receive a promotion or reclassification, or any expectation of these matters may not be covered by the legislation.

WorkCover WA is the independent government agency responsible for the administration of the workers' compensation and injury management system in Western Australia.

PROCEDURE:

Injury Management steps:

1. Responsibilities of an Injured Employee:

All **employees have an obligation to report hazards** and all incidences that result in an **injury** or are **near misses** to the line manager. If an employee has been injured, they are to:

1. Administer first aid and seek medical attention if required

Injured workers have 12 months from the date of injury in which to make a workers' compensation claim for lost wages and/or medical costs. If immediate medical attention is not required, it can be sought if the injury progresses in days or weeks following the incident.

2. Provide a **first medical certificate** to FRSA Administration via line manager as soon as possible.
3. Complete an accident / incident report – staff, as found in appendix 2.

If Workers' Compensation is being sought, then the injured employee must:

4. Complete a **Workers' Compensation Claim Form** (appendix 1).
5. Return completed forms to **FRSA Administration** (via the line manager) with the **first medical certificate**; attend medical reviews and appointments with rehabilitation providers.
6. Provide ongoing workers' compensation medical certificates to FRSA Administration (via the line manager).

Notes:

The details to be provided to a medical practitioner section in the Workers' Compensation claim form will be completed by the workers' compensation officers in the Employee Support Bureau on receipt of the claim form, where appropriate.

2. Responsibilities of Line Managers:

Line managers must manage an employee who suffers a workplace accident causing injury or illness in accordance with these procedures. Providing early assistance and open communication are important

factors in supporting an injured or ill employee. The procedures below must be followed to ensure that the employee receives the necessary medical treatment and support to facilitate his or her return to work.

When a member of staff is injured the Line Manager must:

1. **Ensure first aid** is provided, if required.
2. Advise the employee to **seek medical assistance** if required. (If not urgent then the employee can seek assistance if and when the need arises.).
3. Investigate the incident and complete an **incident/accident investigation form** and report the incident to the Occupational Safety and Health (OSH) representative. (The investigation is required under occupational safety and health legislation).
4. **Maintain records** of incident/accident reports (it is essential records are kept in case the employee lodges a claim at a later date).

3. FRSA Administration:

1. On receipt of the **first medical certificate** from the employee notes the information regarding work capacity. (If the employee lodges a first medical certificate without a Workers' Compensation claim form contact the employee immediately to advise that a Workers' Compensation form must be completed to lodge a claim for compensation).
2. Complete an **Employer Report Form** and send with the **first medical certificate**, Workers' Compensation claim form and the accident/incident investigation form to the insurance provider.

4. The line manager is also responsible for supporting an injured worker to return to work.

In order to do this the line manager must:

1. Identify possible **productive and meaningful alternative duties** or make modifications to original duties for consideration by the medical practitioner
2. Where an employee is fit to return to work but only on restricted duties or hours, ensure that a written **return to work program** is developed and implemented. A return to work program is to be developed in consultation with the injured worker and based on the restrictions on the medical certificate or advice from the treating medical practitioner
3. Send a copy of the **return to work plan** to FRSA Administration (Human Resources)
4. Human Resources to maintain relevant confidential documentation, such as copies of medical certificates, in a secure location
5. Respect the privacy of the injured employee. No information regarding the injured employee's injury or rehabilitation status is to be communicated to unauthorised staff without the permission of the employee.
6. **Liase with the nominated vocational rehabilitation provider** regarding the rehabilitation program.

Supporting an injured / sick employee when he or she is absent:

Management support is vital to the success of an employee's return to work program. It is important to let the employee know that he or she is a valued staff member. Strategies which line managers may find useful include:

- **Regularly contacting an injured or unwell employee who is totally unfit.**
- **Attending an appointment with the employee and medical practitioner** (with the consent of the employee) to determine the level of support required to assist him or her return to work and to advise the medical practitioner of available alternative duties.
- **Advising the employee** of the availability of **counselling**.
- **Forwarding copies** of newsletter, relevant memos and **school matters**.
- **Extending social invitations** to the employee (the employee requires medical approval to attend work-related meetings).

Workers' Compensation does not entitle Super Guarantee Contributions (SGC) of the employee. FRSA is committed to paying 4 weeks of SGC over the Workers' compensation payment. If Workers' Compensation exceeds 4 weeks, SGC will cease.

Return to work programs must be in writing and have the signature of the injured employee and the line manager indicating that they agree with the details and goal of the program. The relevant workers' compensation forms must be completed, copied and stored so that confidentiality is maintained. It is necessary that line managers keep records of all matters that may become the subject of a compliant, grievance or future dispute.

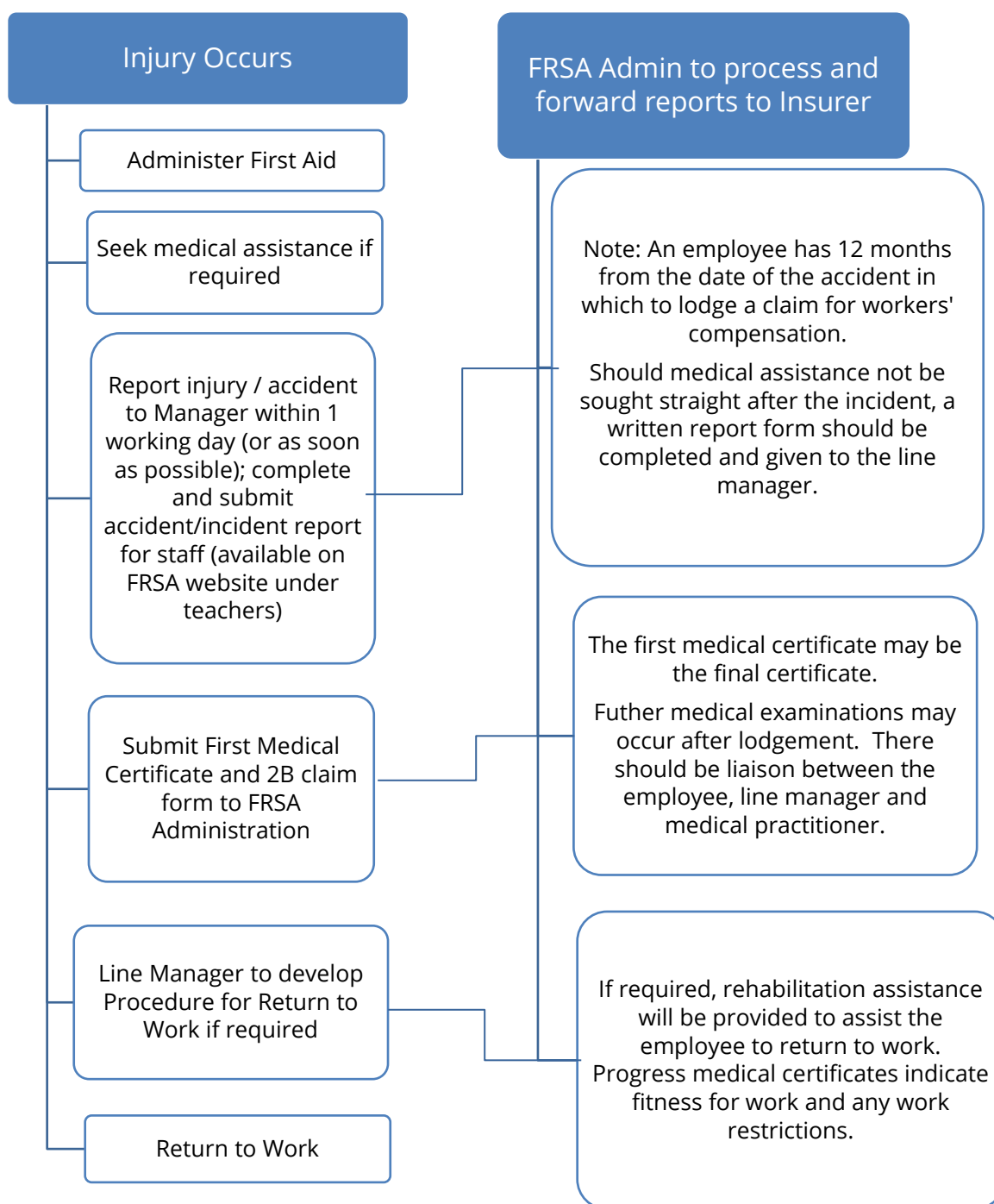
A **copy** of the written return to work program must be sent to FRSA Administration.

Identifying the early signs of Stress:

Effective stress management involves learning to identify the early signs of an employee experiencing stress. The cause of the stress may be a combination of work and on work related issues. Management may observe one or more of the following signs:

1. Behavioural signs such as social withdrawal; uncharacteristic behaviour; increased mistakes; rapid or slow speech; critical and cynical attitudes; frequent, unexplained sickness absence and frequent medical visits for minor health complaints.
2. Physical signs (such as disturbed sleep, fatigue, upset stomach, headaches and agitation).
3. Emotional signs (such as anxiety, tearfulness, irritability and over-sensitivity).
4. Cognitive signs (such as reduced concentration, forgetfulness and diminished decision-making capacity).

Flow chart of workers' compensation injury management process:



Workers' Compensation Claim Form

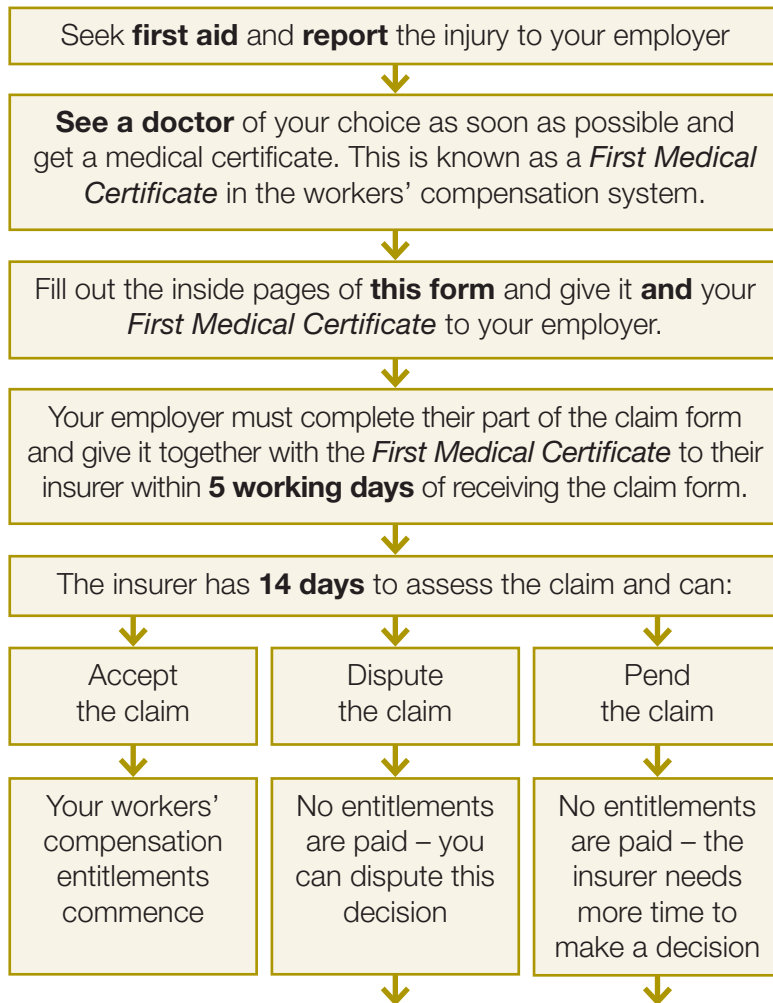
Workers – tear off and keep this section for your information



Who can make a claim?

You are entitled to make a claim if you sustain an ***injury in the course of your employment and are defined by law as a worker***. The legal definition of a ***worker*** includes full-time, part-time, casual, seasonal, piece and commission workers. Working directors, contractors and sub-contractors may also be defined as workers depending on their working arrangements.

How to claim:



What happens if you don't agree with the insurer's decision?

Your employer's insurer has an internal dispute resolution process. You can approach the insurer to re-examine their decision.

In addition, WorkCover WA provides assistance regarding resolving disputes.

To find out more about having a dispute resolved or for general information about workers' compensation and injury management contact **WorkCover WA's Advisory Services on 1300 794 744**.

How to make a claim with self-insurers

Some employers have been approved by WorkCover WA as self-insurers. This means that the employer covers the cost of its workers' compensation claims.

The process for making a workers' compensation claim is the same. However your **employer has 17 days** to assess your claim once they receive your completed claim form and **First Medical Certificate**.

You can ask your employer if they are a self-insurer. A list of self-insurers is available on the WorkCover WA website at www.workcover.wa.gov.au under Service Providers.

What happens when my claim is pended?

An insurer can pend your claim if they need more time or more information to make a decision. They may contact you during this time for more information about your claim.

While your claim is being assessed, consider using any accrued leave (sick leave or annual leave) to provide you with interim financial support. If your claim is accepted, any leave you have used will be reinstated by your employer.

If a decision has not been made within **19 days** of you lodging your claim form and **First Medical Certificate** with your employer, you should contact Advisory Services on 1300 794 744 for more information.

WorkCover WA is the government agency responsible for overseeing the **Workers' Compensation and Injury Management Act 1981**.

What does workers' compensation cover?

Once your claim is accepted you become entitled to workers' compensation payments. These may include:

- **wages** that should be paid on your normal pay day for any time that your doctor has certified you unfit for work
- **medical expenses** for hospital, medical and allied (eg physiotherapy) health treatment referred by your doctor and approved by the insurer. Your medical expenses are covered only up to a workers' compensation rate which is set by WorkCover WA. Be sure to check that your doctor charges this rate otherwise you may be left with a gap payment
- **rehabilitation expenses** to cover the cost of engaging an **approved workplace rehabilitation provider** to help your return to work
- **travel and accommodation** expenses in certain situations.

Contact WorkCover WA for publications about your rights, responsibilities and entitlements.

Wages, medical and rehabilitation payments are limited and subject to maximum amounts. You can call our Advisory Services staff on 1300 794 744 or visit www.workcover.wa.gov.au/Workers for further information.

While your claim is being assessed, you can ask your employer to pay you sick leave or annual leave you have already accrued. If your claim is accepted, you will receive your workers' compensation entitlements and your employer will reinstate your leave. **Remember you must have a medical certificate to cover any time you are away from work.**

Know and understand your rights and responsibilities

You:

- have the right to **choose your own treating doctor** and **workplace rehabilitation provider**
- have the right to **claim lost wages from other jobs** if you have another job/s your injury prevents you doing
- have the responsibility to **attend certain medical appointments** at the request of your employer
- have the responsibility to fully participate in your **return to work program** once developed.

Your employer:

- has the right to **request a medical review** via their insurer before or after a claim has been accepted
- has the **right to discuss your return to work** with the treating doctor
- has the responsibility to have an **injury management system in place** and implement a **return to work program** when a doctor declares you fit for work in any capacity
- has the responsibility to keep **your original position available** for 12 months following a claim.

Together:

- you have the responsibility to work with your treating doctor in developing an appropriate **return to work program**.

Disclosure of Personal Information (consent authority)

Your employer's insurance company needs to collect, use and disclose personal information to assess, investigate and otherwise deal with your claim. **If you do not provide the information requested, this may affect the insurer's ability to assess your claim. This may cause significant delays in the claims process.**

By signing the *consent authority* on the Claim Form, you agree to the insurer:

- a. collecting and using your personal information for the purpose of assessing, investigation and otherwise dealing with your current claim or any future claims.
- b. disclosing personal information (on a confidential basis) to and collecting personal information from:
 - your employer, the insurer's entities, its investigators, auditors, medical service providers or any other party providing services to the insurer or any agent of these
 - other insurers, insurance intermediaries, government regulators or insurance reference bureau
 - lawyers and law enforcement agencies.

Checklist and handy hints

For the Worker

- ☐ Complete the form with a ballpoint pen.
- ☐ If you need help completing the form, you can get your employer, a friend or family member to help you or you can call WorkCover WA on 1300 794 744. If required, an interpreter can also be arranged by WorkCover WA free of charge.
- ☐ The claim form is printed on carbonised paper which produces an exact copy on the sheet below it. Make sure you write on the centre sheets only and press firmly.
- ☐ Provide **all** the information requested. Give your full name, postal and email address and daytime contact phone number in case you need to be contacted.
- ☐ It may be helpful to attach a separate sheet to your claim form **if more space is needed** to provide information about your injury, how it happened and your medical history.
- ☐ Read and sign the **worker's declaration** and the **consent authority (optional)**.
- ☐ Attach the **First Medical Certificate** you received from your doctor to this claim form (your claim cannot be processed until both your claim form and **First Medical Certificate** are received).
- ☐ Keep records! Take a photocopy of your claim form and keep a record of the date you gave the claim form and medical certificate to your employer.
- ☐ Tear off the information section of this form and keep for your future reference.

For the Employer

- ☐ **Tear off the information section of this form and give it to the injured worker.**
- ☐ Make sure the worker has completed all sections of the claim form. If they have difficulty completing it, let them know that they can seek help from you, or a family member or friend.
- ☐ Make sure you complete the employer details section.
- ☐ Review the **First Medical Certificate**. Has the doctor indicated that the worker has **capacity to work** in either their pre-injury job or in alternative duties? If so, you are required by law to **develop a return to work program**. Visit the WorkCover WA website www.workcover.wa.gov.au for further information and templates or contact your insurer for assistance.
- ☐ If the doctor has indicated that the worker will be off work for more than three days or can't return to normal duties, they will be expecting you to contact them.
- ☐ Keep records! Develop a case file, photocopy all relevant paperwork and keep it in a safe and private location and date all correspondence.
- ☐ Forward this form to your insurer within **five working days** of receiving it. Make sure you attach:
 - the worker's **First Medical Certificate** and any subsequent medical certificates
 - medical accounts (if any)
 - any other reports your insurer asks you to complete.
- ☐ If an injury is likely to prevent an employee from working for **10 consecutive days**, you must also notify WorkSafe on (08) 9327 8800. A list of reportable injuries and diseases can be found at www.commerce.wa.gov.au/WorkSafe. There are also reporting requirements for **all injuries in the mining sector**, for more information visit www.dmp.wa.gov.au.

Workers' Compensation Claim Form

Insurer please complete

Insurer name

Claim number

ANZSIC Code

Policy number

WorkCover number

Has employer contacted medical practitioner? ☐ Y ☐ N

Estimated time off work:

☐ less than one day

☐ 1-4 work days (inclusive)

☐ 5-9 work days (inclusive)

☐ 10-20 work days (inclusive)

☐ more than 20 work days

☐ fatality

Date form received from employer

DATE STAMP

ASCO (office use only)

Employer please complete

Name of policy holder/employer:

Trading as (if different to above):

Address: Postcode:

Contact person name: Phone No: Email:

Address of injured worker's usual workplace or base: Postcode:

Major activity of workplace (eg sheep farming, plumbing):

Date employer received the completed claim form from the injured worker:

Date employer received First Medical Certificate from the injured worker:

Date employer sent the claim form and medical certificate/s to insurer:

Worker please complete

Surname: <input type="text"/>	D.O.B. <input type="text"/> <input type="checkbox"/> Male <input type="checkbox"/> Female
Other names: <input type="text"/>	Preferred language (if not English) <input type="text"/>
Address: <input type="text"/>	At the time of the injury I was working as a:
Suburb/City/Town: <input type="text"/> Postcode: <input type="text"/>	<input type="checkbox"/> direct employee <input type="checkbox"/> sub contractor
Email: <input type="text"/>	<input type="checkbox"/> working director <input type="checkbox"/> visa worker
Daytime contact phone no: <input type="text"/>	<input type="checkbox"/> contractor <input type="checkbox"/> other
Occupation (eg first class welder) <input type="text"/>	<input type="checkbox"/> employee of contractor <input type="text"/> If other, please specify:
Main tasks/duties performed (eg welding of high pressure steam pipes) <input type="text"/>	
<input type="checkbox"/> full time (F) <input type="checkbox"/> part time (P) <input type="checkbox"/> permanent (P) <input type="checkbox"/> temporary (T) <input type="checkbox"/> casual (C)	

Other Employment

If more than one employer, please attach details on separate sheet

Do you have any other job? ☐ Y ☐ N If yes, please give details:

Employer name: Phone no: Hours per week:

Occurrence details

Attach separate sheet if more space is required

Day of occurrence: eg Monday <input type="text"/>	Date of occurrence: <input type="text"/>	Time of occurrence: <input type="checkbox"/> AM <input type="checkbox"/> PM
At what address did the occurrence happen? <input type="text"/>		
Did you have to stop working? <input type="checkbox"/> Y <input type="checkbox"/> N	If so when? Date: <input type="text"/>	Time: <input type="checkbox"/> AM <input type="checkbox"/> PM
Were you: <input type="checkbox"/> working – at your normal workplace <input type="checkbox"/> on work break – at normal workplace <input type="checkbox"/> working – away from normal workplace <input type="checkbox"/> on work break – away from normal workplace <input type="checkbox"/> working – road traffic accident commuting/journey <input type="checkbox"/> other duty status	Describe the occurrence. Include: (i) What action was involved (ie fall, struck by object) <input type="text"/> (ii) What object/machine/substance was involved (ie fumes, door frame) <input type="text"/> (iii) The most serious injury or disease caused (ie fracture, burn, abrasion) <input type="text"/> (iv) The bodily location of the injury or disease (ie upper arm, eye) <input type="text"/>	WorkCover WA Staff Only Mechanism <input type="text"/> Agency <input type="text"/> Nature <input type="text"/> Bodily location <input type="text"/>

Worker please complete

Occurrence report – Describe how it happened

Attach separate sheet if more space is required

Where did the occurrence happen? (ie store room, machinery shop)

What were you doing at the time of the occurrence?

What were the normal working hours for that day? Starting time: ☐ AM ☐ PM Finish time: ☐ AM ☐ PM

When did you first report the occurrence? Date: _____ Time: ☐ AM ☐ PM

Who did you report the occurrence to?

Name: _____ Position: _____ Phone No: _____

If you didn't report the occurrence immediately, please state the reason if any:

Please provide the name and daytime contact phone number of witnesses of the occurrence:

1. Name: _____ Phone No: _____

2. Name: _____ Phone No: _____

Medical help/history – this occurrence

Attach separate sheet if more space is required

When did you first seek medical attention? Date: _____ Time: ☐ AM ☐ PM

If not immediately, please state the reason:

Was the part of the body affected by this occurrence healthy before this occurrence? ☐ Y ☐ N

If not, please give details:

Is the present injury completely related to this occurrence? ☐ Y ☐ N If not, please give details:

Please give details of any similar injury prior to this occurrence:

Name and contact details of your usual medical practitioner and any health provider who has treated you for a similar injury:

Name: _____ Address: _____ Phone no: _____

Other/Previous claims

Attach separate sheet if more space is required

Are you claiming compensation from any other source? ☐ Y ☐ N If yes, from whom?

Have you had any similar or related workers' compensation claims? ☐ Y ☐ N If yes, please give details:

Name of Employer: _____ Address: _____

Name of insurer (if known): _____ Type of injury or disease: _____

Worker's declaration

I solemnly and sincerely declare that each and every answer above and the particulars contained herein or annexed hereto relating to myself and the occurrence are true both in substance and in fact to the best of my knowledge and belief. I take notice that, under the provisions of section 59(2) of the *Workers' Compensation and Injury Management Act 1981*, I am required to notify my employer in writing within 7 days if I commence work with another employer after making a claim, or while receiving weekly payments of workers' compensation.

Dated this: _____ day of: _____ Year: _____

Signature of worker _____ Signature of witness _____

Consent authority (to be signed at the option of the worker) I authorise any doctor who treats me (whether named in this certificate or not) to discuss my medical condition, in relation to my claim for workers' compensation and return to work options, with my employer and with their insurer.

Dated this: _____ day of: _____ Year: _____

Signature of worker _____ Signature of witness _____

Consent authority – to be signed at the option of the worker

I consent to my employer's insurer and its appointed service providers collecting personal information, inclusive of sensitive information such as medical information about me and using it for the purpose of assessing and managing my workers' compensation claim, including determining liability and whether my claim is true. This consent extends to my employer's insurer disclosing my personal information, inclusive of sensitive information, to other insurers, medical practitioners, rehabilitation providers, investigators, legal practitioners and other experts or consultants for the purpose of assessing and managing my claim. My personal information, inclusive of sensitive information, may also be disclosed as required or permitted by law. I also consent to my employer's insurer disclosing my personal details to WorkCover WA which is authorised to use this information to fulfil its functions and obligations under the *Workers' Compensation and Injury Management Act 1981*. I have read all the information on this form regarding the consent authority and I consent to the Insurer dealing with my personal information in the manner described.

Signed _____ Witness signature _____

Print your name _____ Witness print name _____

Date _____ Date _____

IMPORTANT: FAILURE TO PROVIDE YOUR SIGNATURE ON EITHER THE DECLARATION OR THE CONSENT AUTHORITIES MAY DELAY A DECISION BY THE INSURER ON YOUR CLAIM

Further information and assistance

WorkCover WA is the government agency responsible for overseeing the *Workers' Compensation and Injury Management Act 1981* (the Act) in Western Australia.

The role of WorkCover WA is to monitor compliance with the Act, inform and educate parties on all aspects of the workers' compensation and injury management system and provide an independent dispute resolution service.

If you would like further information about workers' compensation and injury management or information about seminars for injured workers contact:

WorkCover WA

2 Bedbrook Place
Shenton Park WA 6008

Advisory Services 1300 794 744

TTY (hearing impaired) (08) 9388 5537

www.workcover.wa.gov.au

An interpreter service is available by arrangement with WorkCover WA.

Injury Management

Injury management is about managing workers' injuries in a manner that is **directed at enabling injured workers to return to work.**

Your employer should have a **written description of an injury management system** in your workplace and this should be made available to you if you ask for it.

You should be involved with decisions regarding your return to work.

It is important for you to:

- keep in touch with your employer, your doctor and other treatment providers
- submit medical certificates to your employer as soon as possible and on a regular basis to help keep your employer informed of your medical condition and level of fitness for work.

If your treating medical practitioner finds that you are partially fit to return to work in some capacity, a written return to work program will be established by your employer.

Workers should fully participate with their employer and medical practitioner in developing an appropriate return to work program. This will help develop a supportive environment that has the commitment of all parties to a successful return to work process. You have the responsibility to actively participate in your return to work program once developed.

Make sure you have a say in determining your future at work by being involved in discussions that affect you.

Publications for workers, employers and insurers are available from WorkCover WA.



Appendix 2

Accident / Incident Report - Staff

This form is available on the FRSA website

Accident / Incident Report - Staff



School / Department: _____

Date and time of accident: _____ Location: _____

Name of person injured in the accident/incident: _____

Details including cause of the accident/incident:

Action taken, and treatment involved:

Who did you report the occurrence to?

If you didn't report the occurrence immediately, please state reason:

Name of witness(es) to the accident/incident:

Signature (injured staff): _____

Date: _____

Follow up required:

Manager / Principal Signature: _____

Date: _____

Follow up action taken by: _____

Signature: _____

Date: _____

THIS REPORT IS TO BE FORWARDED TO FRSA ADMINISTRATION



Appendix 3

Return to Work Program Template

(Where applicable)

Return to Work Program

Worker Details

Worker Name: _____ Claim No: _____
Address: _____
Telephone (home): _____ Telephone (work/mobile): _____
Email: _____
Position Title: _____ Section: _____

Employer Details

Employer/Business Name: _____ Free Reformed School Association
Address: _____ 18 Robin Hood Av, Armadale, WA 6112
Supervisor: _____ Telephone (work/mobile): _____
Email: _____
Person coordinating return to work program: _____
Telephone: _____ Email: _____

Insurer Details

Name of Insurer: _____ Zurich Insurance
Address: _____ Locked Bag 994, North Sydney NSW 2059
Contact person: _____ Telephone: _____ 131 551
Email: _____ client.service@zurich.com.au

Medical Details

Name of Treating Medical Practitioner: _____
Address: _____
Telephone: _____ Email: _____

Return to Work Goal

New Employer / New Job

Other Workplace Rehabilitation¹ Options

Same Employer / New Job

Review Date: / /

[illegible]

Actions to Enable the Injured Worker to Return to Work:

Action	Person Responsible	Completion/ Review Date

Return to Work Goal (tick the relevant box)

<input type="checkbox"/>	Same worksite Original Duties	<input type="checkbox"/>	Same Worksite Modified duties	
Start Date: ____/____/____		Review Date: ____/____/____		
Week	Date	Hrs of work	Duties	Restrictions
1				
2				
3				

Note: These details are only included if the worker, the employer and the treating medical practitioner have agreed to a referral to an approved workplace rehabilitation provider.

Name of Approved Workplace Rehabilitation Provider: _____

Address: _____

Telephone: _____

Email: _____

Date of Referral: / /

I agree to the content of this Return to Work Program.

Worker's Signature: _____

Date: / /

Employer's Signature: _____

Date: / /

Name of person signing on behalf of employer: _____

Position: _____



Appendix 4

WorkCover WA Workplace Rehabilitation Referral Form

Provider

Provider

Please forward the form directly to the Provider.

1. Worker's Name

Date of Birth

Claim number

Injury type

Worker's
address

	Telephone		
	Insurer		Date of

2. Referring source

☐ Treating medical practitioner
employer (authority attached)

☐ Employer

☐ Insurer on behalf of

3. Referral type

☐ **Workplace rehabilitation assessment** (Medical practitioners and employers must always consult with each other and the worker prior to the referral for rehabilitation assessment)

Specific service (please indicate) (See over for further description)

☐ Functional capacity assessment

☐ Job demands assessment

☐ Ergonomic assessment

☐ Workplace assessment

☐ Other

☐ I have discussed this referral with the worker and their ☐ **Employer** or ☐ **Treating medical practitioner** and they are in agreement.

Referrer's
name

Referrer's
signature

Date

4. Employer's details

Company

Contact

Address

	Telephone	

Treating medical practitioner details

Practice

Address

	Telephone	

5. Section to be completed by workplace rehabilitation provider

Has workplace rehabilitation programme previously been undertaken with you or another provider?

☐ Yes ☐ No

Interpreter
required?

☐ Yes ☐ No

Date of worker's last
recurrence

Referral type

☐ Assessment ☐ Specific service

Date referral
received

Did this current referral proceed to
assessment/specific service?

☐ Yes ☐
No

If **No** please
indicate

☐ 1st Schedule
Redemption

☐ 2nd Schedule
Redemption

☐ Common Law
Election

Other

Costs

Rehabilitation Provider:

Please enter details into the Online Rehabilitation application within 28 days of receipt of referral and retain copy on worker's file.

How to make a Workplace Rehabilitation Referral

Where factors are identified that may interfere with an employer's ability to develop a return to work program for an injured worker, the assistance of an approved workplace rehabilitation provider may be sought. Either the employer or treating medical practitioner is able to initiate a referral, in consultation with the other key parties.

Referral Type

There are two types of referrals that can be made:

1. Referral for a **Workplace Rehabilitation Assessment:**

This form of referral requires consultation between all **key parties**, that is, the treating medical practitioner, employer and injured worker. Consultation refers to verbal or written communication between those key parties obtaining support for the referral. For example, if you are an employer requesting the referral, you are required to consult with the treating medical practitioner and indicate this by ticking the box.

If a referral is required for an assessment it may or may not proceed to a full rehabilitation program.

Examples of when a referral for assessment may be required include:

- If the injured worker, due to their injury, cannot carry out pre-injury duties
- If there is a need to assess the suitability for a return to work programme with a new employer
- To determine the need for retraining
- There is difficulty determining suitable duties.

2. Referral for **Specific Services:**

A referral for a **Specific Service** can be initiated by either the employer or treating medical practitioner in consultation with the worker. This referral is for a one-off intervention or specialist service.

In both cases the referring party must indicate that they have consulted with the worker and the worker has nominated the chosen provider.

A list of Approved Workplace Rehabilitation Providers is available from WorkCover WA.

Types of specific Workplace Rehabilitation Services

Specific Services are a one-off intervention or specialist service required to assist key parties in the injury management coordination. Below are some examples of specific services.

Functional Capacity Assessment

A Functional Capacity Assessment is an assessment the worker's functional capacity. This assessment objectively measures an injured worker's physical abilities and limitations.

This assessment is best utilised when a specific job or duties have been identified and clarification of the injured worker's physical ability to undertake the identified job is required.

Ergonomic Assessment

Activities associated with assessing how a particular work environment would affect the worker. Can include the delivery of client training and education for injury management and related topics, e.g. back education and relaxation and stress management.

Job Demands Assessment

Identifies the full range of demands of a specific job e.g. physical, cognitive, sensory and psychological demands.

This can assist a medical practitioner understand the full range of requirements of particular jobs. It is important the medical practitioner understands the job requirements, so they can provide appropriate medical clearance and assist setting realistic vocational goals.

Workplace Assessment

Activities associated with assessing the suitability of various workplace alternatives and other job options to identify possible suitable duties or make recommendations for workplace modifications and/or job redesign to accommodate an injured worker's return to work or promote a safe work environment.

This assessment can be of benefit when an employer is unsure if they have any duties that would be suitable for the injured worker in their workplace or the treating Medical Practitioner requires advice if the employer has any duties that would be suitable for the injured worker. It is also of assistance if job redesign or additional equipment would assist the injured worker to return to work.