



# DEFAULT INSURANCE FUND

GPO Box 158  
 Canberra ACT 2601  
 Phone: 02 6207 0723  
 Fax: 02 6207 0301  
[www.treasury.act.gov.au/actia/difund](http://www.treasury.act.gov.au/actia/difund)

## INJURY NOTIFICATION FORM FOR UNINSURED EMPLOYERS

<b>Employer Information</b>	
Name:	
Address:	Post Code:
Employer Contact:	
Phone Number:	Fax Number:
<b>Injured Worker Information</b>	
Surname:	First name:
Date of Birth:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Address:	Post Code:
Phone Number:	Mobile:
Occupation:	
<b>Accident/Injury details</b>	
Date of Accident:	Time of Accident:
Date reported to employer:	Time reported to employer:
Type of Injury/Disease Suffered (eg fracture, strain etc):	
Part of body injured (eg lower back, right arm etc):	
Describe how the injury occurred/Cause of Injury:	
Address where accident occurred:	
Has the worker lost any time from work: YES/NO	
Date Ceased:	Date resumed:
Was the accident witnessed:	
Name of Witness:	
Position held:	Phone Number:
Mobile Number:	Fax Number:
<b>Treating Doctor Information</b>	
Name of Medical Practice:	
Name of Doctor:	
Address of Medical Practice/Doctor:	
Phone Number:	Fax:
<b>Signature:</b>	
Name of person reporting/registering injury details:	Employer Signature:
	Date:
Workers Declaration and Consent: I declare that the above information is correct and hereby authorise any medical practitioner or treatment provider to provide the DI Fund or my employer with any medical information in relation this injury.	Workers Signature:
	Date:
	Time:
Privacy: Please view the Default Insurance Fund Privacy Charter with regard to the collection, security, accessibility, use and disclosure of personal information. It can be viewed at: <a href="http://www.treasury.act.gov.au/actia/difund">www.treasury.act.gov.au/actia/difund</a>	