



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

() ()

Have you even been known by another name?

No
Yes Give details below

Surname

Given name(s)

Are you legally represented?

No
Yes Give details

Name of firm

Name of solicitor

Date you first consulted a solicitor

Date you first identified the respondent

2. Accident/Incident Details

- How were you injured?
- Motor Vehicle Accident
 - Work Accident
 - Health Providers Act or Omission
 - Public Liability
 - Other

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

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

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

Home phone number

Work phone number

Witness 2

Surname

Given name(s)

Home address

Home phone number

Work phone number

Who in your opinion, other than the respondent, caused the accident?

Surname

Given name(s)

Home address

Home phone number

Work phone number

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

Have you lodged a claim?

No

Yes Give details below

Date claim lodged

Claim number

3. Medical Details

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

Did you go to hospital after the accident?

No

Yes Name of hospital

Date

Who has treated you for your injuries since the accident?

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

Name

Address (practice or surgery)

<input type="text"/>
<input type="text"/>
Postcode
Phone number ()

What treatment or rehabilitation have you had?

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

4. Employment details

Have you lost income as a result of this accident/incident?

No

Yes

Please advise your employment status

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

Please provide your employment details

Name of employer

Contact person's name

Contact phone number

Workplace address

<input type="text"/>
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

<input type="text"/>
<input type="text"/>
<input type="text"/>

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

No

Yes Give details below

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

If self employed:

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

No

Yes Give details below

Name and nature of business

Accountants name

Accountants contact details

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).

\$

5. 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

Place

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

No

Yes If yes, please provide details

Date

Time

Place

Warning given:

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

Yes

No

Was it written or oral consent?

Written

Oral

When and where was the consent given?

Place

Date

Motor Vehicle Accidents

If the injury was caused by a motor vehicle accident, please complete the following questions otherwise turn to the next page

Do you have the registration number of the vehicle you consider at fault?

No There is an obligation on you as the claimant to provide evidence of steps taken to find out the registration number or the owner of the vehicle you consider at fault. Please list any action taken by you to find the registration number or the name of the person who drove the vehicle you consider at fault. (Please attach any proof such as newspaper advertisement or discussions with any witnesses etc)

Yes Give details below

Registration number

Type of vehicle (if known)

Vehicle you were travelling in

Registration number

Type of vehicle

If you were a driver/passenger, were you wearing a seat belt?

No

Yes

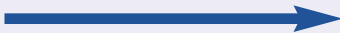
If you were a motorbike rider/cyclist, were you wearing a helmet?

No





Yes

Diagram of Accident

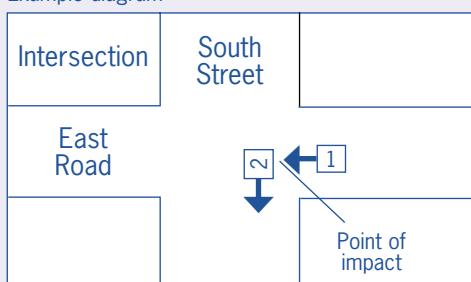
Draw a diagram of the accident. Include all intersections, streets, roads and their names. Show the point of impact and position of vehicles.

Use this box 

Symbols

-  vehicle that caused the accident
-  other vehicle(s)
-  etc
-  pedestrian, cyclist, etc

Example diagram



Authorisation

Given name(s)

Surname

address

<input type="text"/>	
<hr/>	
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 injured 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

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

Details of the person who signed

Surname

Given name(s)

Home phone number

Work phone number

Relationship to the injured person

Reason why the injured person could not sign