WorkCover/Third Party Registration Form

This information will be recorded on your medical certificates.

DATE:……………………………………..

NAME & SURNAME: ……………………………………………………………….…………………………

INSURER: Please circle

WorkCover Qld Gallagher Bassett City Cover Comcare Other:……………………..

CLAIM NO:………………………………………

CASE MANAGER:………………………………………………………tel: ………………………………..

OCCUPATION:…………………………………………………………………………………………………..

EMPLOYER'S NAME:…………………………………………………tel:…………………………………

COMPANY NAME:…………………………………………………..tel:…………………………………

COMPANY ADDRESS: ………………………………………………………………………………….

…………………………………………………STATE……………………P/CODE……………………....

DATE OF INJURY:………………………………..

TYPE OF INJURY:………………………………………………………………………………………….

In your words, how did this injury occur?………………………………………………………………

………...

………...

Office Use Only

Approved by: ……………………………………………………………………Date: ………………………….

Above information advised by the following: Please circle

Patient Employer Insurer Other:…………………………..………....