

Recurrence / Aggravation of Injury

TO BE COMPLETED WHERE A WORKER HAS LOST FURTHER TIME FOLLOWING A RETURN TO WORK OR WHERE THERE HAS BEEN A RENEWAL OF TREATMENT OF THE ORIGINAL INJURY.

ATTACH MEDICAL CERTIFICATE AND REPORTS IF AVAILABLE.

CLAIM NO. (Office use only)

PPS Yes ☐ No ☐

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1 Worker

Surname			Other Names		
Address				Postcode	
Current Employer			Claim No. (if known)		
Employer at time of original injury					
Nature of injury					
Date of original injury		/ /		Date of further period of incapacity	
				/ /	
Date of return to work		/ /			

2 Recurrence / Aggravation details

1. (a) Describe in detail where you were and what you were doing when the latest onset of symptoms or incapacity occurred

(b) If a further incident occurred, please provide details of this further incident

2 Recurrence / Aggravation details (continued)

2. Were there any witnesses to the onset of further symptoms?

Yes ☐ No ☐

If 'Yes', provide names and address, and attach statements

3. Was the onset of symptoms reported? Yes ☐ No ☐ If 'Yes', when? / /

and to whom?

4. (a) State what symptoms, if any, you have been experiencing leading up to the latest onset of symptoms

(b) What medical treatment have you been receiving prior to the latest onset of symptoms?

State the names of treating Doctors and dates of treatment

5. Give full details of your employment between the date of the original injury and the recurrence / aggravation.

Supply names of all Employers, dates worked and Occupation

3 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 *Workers Compensation and Injury Management Act 2023* (WA), I am required to notify my employer or insurer within 7 days if I commence paid work with another employer after making a claim, or while receiving income compensation.

I hereby authorise any Doctor to divulge to my Employer, or their Insurer, information in relation to my claim for workers' compensation which he or she may have acquired with regards to myself.

Dated this _____ day of _____ 20____

Signature of Worker

Date

X

/ /

Signature of Witness

Date

X

/ /

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