Personal Injury
Commission

Matter Number

Form 1 - Application for Expedited Assessment

Notice to Parties

Notice to Parties

NOTICE TO APPLICANT

Use the table below to decide the appropriate form.

Claim Type	Form Type
Weekly benefits work capacity only	Form 1
Weekly benefits up to 12 weeks and/or past medical expenses up to $9,722*	Form 2
Weekly benefits work capacity and past medical expenses greater than $9,722* and/or any future medical expenses	Form 2
Weekly benefits more than 12 weeks and/or past medical expenses greater than $9,722* and/or any future medical expenses	Form 2

***Note:** The amount of $9,722 is subject to adjustment under Division 6 of Part 3 of the Workers Compensation Act 1987. See also the Workers compensation benefits guide issued by the State Insurance Regulatory Authority.*

Failure to attach all relevant documents identified in this section will result in your application being rejected by the Commission.

NOTICE TO RESPONDENT

The respondent has 7 days to lodge and serve on the applicant a Form 1B – Reply to Application for Expedited Assessment.

NOTICE TO PARTIES

The application and the reply must comply with the Personal Injury Commission Rules 2021, Procedural Direction WC2 – Interim payment directions and/or Procedural Direction WC5 – Work capacity disputes.

PRIVACY NOTICE

Maintaining the privacy of personal information and health information is important to the Personal Injury Commission (Commission). The Commission collects and uses personal information and health information to exercise its statutory powers and to carry out its statutory functions as well as other related activities, including to register application forms such as this Form and to make decisions about disputes or claims.

Such personal information and health information may include, but is not limited to, the information contained, or referenced in, this completed Form, any other information which is provided by an Applicant, its representatives or a party or insurer in connection with proceedings before the Commission and/or such other information as may be obtained by the Commission or its members and staff in connection with the Commission exercising its statutory powers and carrying out its statutory functions as well as related activities or complying with any other obligations at law.

The Commission may disclose personal information and health information that it holds to another person (e.g. a doctor or a party to Commission proceedings etc) or to a Commonwealth or State Government department or agency (for example, Centrelink) as required or authorised by law. The Commission may also disclose personal information and health information to the State Insurance Regulatory Authority (SIRA) as required or authorised by law (including under the Workplace Injury Management and Workers Compensation Act 1998 (NSW)) and for the purpose of assisting SIRA to exercise its statutory powers and to carry out its statutory functions.

The Commission's decisions will be published in accordance with section 58 of the Personal Injury Commission Act 2020 (NSW). An application for de-identification or redaction of a decision can be made by a relevant person at any time during the proceedings.

More detailed information about the way that the Commission may collect, use and disclose your information is available at .

Applications to the Commission to access and correct any personal information and health information should be made in writing to the Commission, Level 21, 1 Oxford Street, Darlinghurst, NSW, 2010.

Application for an Expedited Assessment

Application Details

Applicant

Filed by Name

Filed by Party

Matters in Dispute

Medical expenses compensation (where the amount is not more than $9,722.00)

Weekly benefits compensation (up to 12 weeks)

Weekly benefits where work capacity decision in dispute

Compliance Documentation

Decision notice/s attached	Yes	No

Legal Assistance

Is the Applicant in receipt of a grant of legal assistance from the Independent Legal Assistance and Review Service (ILARS)?	Yes	No

Service

Date of Service

Party / Person Served

Method of Service

Address of Service

Suburb State Postcode

Related Claims Details

Worker Details

Worker Details

Surname

Given Name(s)

Filed by Name

Title Other Title Date of Birth

DX Address

Postal Address

Suburb State Postcode

International Address Country

Teleconference Phone Home Phone

Mobile Phone

I consent to receive SMS reminders from the Commission regarding appointments, etc.

Email

Interpreter Required Language of Interpreter

Details of any Special Needs of the Worker

Worker has Representative

Worker Representative Details

Firm or Organisation

Correspondence and documents to be sent to or served at address of representative

DX Address

Postal Address

Suburb | State | Postcode

International Address | Country

Contact Surname

Contact Given Name(s)

Teleconference Phone | Contact Phone

Contact Email

Employer Details

Employer Details

Organisation Name

ABN

DX Address

Postal Address

Suburb | State | Postcode

International Address | Country

Contact Surname

Contact Given Name(s)

Teleconference Phone | Contact Phone

Contact Email

Employer is uninsured

The applicant seeks the following further orders:

1 A declaration that the employer was not insured as required by the Workers Compensation Act 1987 at the time of the worker's injury.

2 Orders:

(1) That the Nominal Insurer pay any compensation and costs awarded against the employer from the Workers Compensation Insurance Fund established under section 154D of the Workers Compensation Act 1987.

(2) That the employer reimburse the Nominal Insurer for:

(a) amounts paid out of the Insurance Fund in respect of compensation and costs awarded against the employer, and

(b) the costs of the Nominal Insurer.

Insurer / Scheme Agent Details

Insurer / Scheme Agent Details

Organisation Name

Branch Name

Claim Number

DX Address

Postal Address

Suburb State Postcode

International Address Country

Contact Surname

Contact Given Name(s)

Teleconference Phone Contact Phone

Contact Email

This Insurer / Scheme Agent has a Representative

Insurer / Scheme Agent Representative Details

Organisation Name

Correspondence and documents to be sent to or served at address of representative

DX Address

Postal Address

Suburb State Postcode

International Address Country

Contact Surname

Contact Given Name(s)

Teleconference Phone Contact Phone

Contact Email

Injury Details

Injury Details

Type of Injury

Date of Injury To Deemed Date

Date of Compensation Claim

Place of Injury

Injury Description /Cause of Injury and Death

Has the worker returned to work Yes No

Provide date of return of work

Weekly Benefits Compensation

Weekly Benefits Compensation

WEEKLY BENEFITS COMPENSATION

Complete this section if you indicated on the first page of the Form 1 that the application is for weekly benefits compensation.

A worker may apply for a determination for past weekly benefits compensation for a period of up to 12 weeks.

A worker who is not receiving weekly benefits compensation may apply for an interim payment direction claiming:

- up to 12 weeks of future weekly benefits, if the dispute is not in relation to a work capacity decision
- up to 10 weeks of past weekly benefits, if the dispute is not in relation to a work capacity decision
- ongoing weekly benefits, if the dispute is in relation to a work capacity decision

You will also need to complete the applicable pre-2012 or post-2012 table below by selecting and adding in the correct table.
For further information see Procedural Direction PIC5
–Schedule of Earnings.

For non-exempt workers who received injuries after 21 October 2019, enter “0” into the “Deductible amount (where applicable)” column in the Schedule of Earnings.

Period of weekly compensation in dispute
If the claim for weekly compensation is a continuing claim, leave the ‘to’ field blank.

Period of weekly compensation in dispute from To

Dependants

No Dependants have been recorded

Additional Details

Industrial Award/Agreement (if applicable)

Classification (if applicable)

Note Any Changes to the Award During the Period Claimed (if applicable)

Note Any Changes to the Acting in a higher position, or promotion (if applicable)

Note Any Changes of Job During the Period Claimed (if applicable)

Medical, Hospital or Related expenses

Medical, Hospital or Related Expenses Details

Past treatment, care or related expenses

Amount sought

Details of past treatment, care or related expenses incurred

Supporting Documents

Supporting Documents

Certification and Signature

Certification and Signature

The Applicant certifies that:

- The applicant is entitled to lodge this application because it satisfies the statutory procedural requirements under section 289 or section 289A of the Workplace Injury Management and Workers Compensation Act 1998 and clauses 44,45 and 46 of the Workers Compensation Regulation 2016.
- The dispute is limited to those matters identified in Part 1 of this form.

Application signed

Date signed