Workers Compensation Commission

Matter No:

/20

(Office use only)

March 2019

Miscellaneous Application

This form may be used for a claim, dispute, or an action for which no other approved form under the *Workers Compensation Commission Rules 2011* is appropriate.

This application is for:

Applicant:

Respondent:

Filed by:

☐ Worker ☐ Self-insurer ☐ Employer

☐ Worker representative ☐ Specialised insurer ☐ Employer representative

☐ Insurer/scheme agent* ☐ icare ☐ Other _____

**Note scheme agent means scheme agent for the nominal insurer*

NOTICE TO APPLICANT

See Guide to Completing Form 20 as to when to use this form for miscellaneous applications.

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

NOTICE TO RESPONDENT

You have 21 days from the date of registration of this application to respond by:
- lodging a reply with the Commission, and
- serving a sealed copy of the reply to each other party.

If you do not respond to the application, the Commission may progress the application in the absence of your reply.

The reply form (Form 2A) may be used to lodge a reply to a miscelleanous application using this form. Form 2A is available from the Commission's website at www.wcc.nsw.gov.au or from the Commission on 1 300 368 040. Employers should contact their workers compensation insurer/scheme agent about lodging a reply.

NOTICE TO PARTIES

The application and the reply must accord with the *Workers Compensation Commission Rules 2011* and the Guide to Completing Form 20 available on the Commission's website at www.wcc.nsw.gov.au.

Date received (Office use only)

PART 1 – Matters in Dispute

Provide brief details of the claim or dispute, including the provision in the workers compensation legislation relevant or applicable to the matter in dispute

PART 2 – Previous Proceedings, Claims and Assessments by Approved Medical Specialists

2.1 Have any proceedings been taken in relation to this injury or any other injury or condition?
☐ No ☐ Yes
If yes, give the court/tribunal details and matter number(s) and attach a copy of the Certificate of Determination or final orders, if any.

2.2 Has the worker been examined at any time by an Approved Medical Specialist under Part 7 of Chapter 7 of the *Workplace Injury Management and Workers Compensation Act* 1998 in respect of this injury or any other injury or condition?
☐ No ☐ Yes
If yes, give the Commission matter number(s) and attach the Medical Assessment Certificate(s).

2.3 Has this claim or injury been subject to a determination on liability by the Workers Compensation Commission?
☐ No ☐ Yes
If yes, give the court/tribunal details and matter number(s) and attach a copy of the Certificate of Determination or final orders, if any.

2.4 Has/have there been (an) award(s) or settlement(s) received in relation to this injury?
☐ No ☐ Yes
If yes, give copies of the award(s)/settlement(s)/consent order(s)/section 66A agreement(s)/complying agreement(s).

PART 3 – Parties Details

Complete only applicable sections of this Part.

3.1 Worker details

Date of birth: / /

Title: ☐Mr ☐Ms ☐Mrs ☐Miss ☐Dr ☐Other

Surname/Family name: Given name(s):

Postal address: Postcode:

Phone number for teleconference:

Email address:

Home phone number:

Mobile phone number:

☐ *Cross this box if correspondence and documents are to be sent to or served at address of the representative.*

Indicate language if the worker needs an interpreter:

Indicate any special needs of the worker: (e.g. wheelchair access)

Preferred city/town/region for conciliation conference/arbitration hearing:
Where a preferred location is not nominated, the Registrar will select the conference or arbitration location based on the nearest location to the worker's address

3.2 Worker representative details

Complete this section only if the worker has a representative

Firm or organisation:

Postal or DX address: Postcode:

Street address: Postcode:
(where interpreter required)

Name of representative:

Phone number for teleconference:

Email address:

Phone number:

3.3 Employer details

Name of business/organisation:

ABN:

Postal or DX address: Postcode:

Contact name:

Phone number for teleconference:

Email address:

Phone number:

3.4 Insurer/scheme agent details

Claim number:

Name of insurer/scheme agent:

Postal or DX address: Postcode:

Contact person:

Phone number for teleconference:

Email address:

Phone number:

Period of risk (if more than one insurer/scheme agent): From: / / To: / /

☐ *Cross this box if this application relates to more than one insurer/scheme agent (additional insurer/scheme agent schedule must be attached)*

3.5 Employer/insurer/scheme agent representative details

Complete this section only if the employer/insurer/scheme agent has a representative

Firm or organisation:

Postal or DX address: Postcode:

Name of representative:

Phone number for teleconference:

Email address:

Phone number:

PART 4 – Injury Details

Date of injury: / / Date of notice of injury: / /

Type of injury:

Place of injury:

Date of compensation claim: / /

Injury description:

PART 5 – Claim Details and/or Orders Sought

Provide details of the claim and/or the orders being sought

PART 6 – Submissions in Support

Provide detailed submissions in support of the claim and/or the orders sought.
If there is insufficient space, insert “See Annexure” and attach the information as an annexure.

PART 7 – Supporting Documents and Information

If there is insufficient space, insert “See Annexure” and attach the information as an annexure.

Note: Supporting documentation is limited to documents that have been exchanged between the parties as and when required by the *Workplace Injury Management and Workers Compensation Act* 1998 and any regulation or guideline made under that Act, and by the *Workers Compensation Commission Rules 2011*.

Document	Author	Date of Document	Start Page
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	

PART 8 – 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.

Applicant's (or representative's) signature: _____Date: / /

Lodgment Details

Hand delivery	Level 20, 1 Oxford Street Darlinghurst NSW 2010
Postal address	PO Box 594 Darlinghurst NSW 1300
Document exchange	DX 11524 Sydney Downtown
Electronic lodgment	registry@wcc.nsw.gov.au

Privacy of Personal Information

The privacy of personal information is important to the Workers Compensation Commission. The Commission collects personal information to register application forms and make decisions about disputes or claims. The NSW workers compensation laws permit the Commission to collect this information.

The Commission may give personal information to another person or agency (e.g. a doctor, a party, State Insurance Regulatory Authority) as required or authorised by law.

Decisions by the Commission will generally be published, including on the Internet, unless there are exceptional circumstances justifying the decision being withheld.

A person has a right to access their personal information and correct any inaccuracies.