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Recurrence of Injury Form

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 certificates and reports if available.

WORKER

Surname Other names

Address

Current employer Claim No (if known)

Nature of injury

Date of original injury / / Date of any further incapacity / /

Did you lose time off work Yes No If Yes, from what date / /

Date of return to work (if applicable) / /

RECURRENCE DETAILS

Describe in detail where you were and what you were doing when the latest onset of symptoms or incapacity occurred

If a further incident occurred, please provide details of this further incident

Were there any witnesses to the onset of further symptoms Yes No
 If Yes, when / / and by whom

State what symptoms, if any, you have been experiencing leading up to the latest onset of symptoms

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

State the names of treating Doctors and dates of treatment.

Give full details of your employment between the date of the original injury and current injury. Supply names of all employers, dates worked and occupation.

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 provisions of Section 59 (2) of the Workers' Compensation and Injury Management Act, 1981, I am required to notify my Employer within 7 days should I commence work with another Employer after making a claim, or while receiving weekly payments of workers' compensation.

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

Date / /

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 Signature of Worker

.....
 Signature of Witness