Employer liability: advice on payments

Details of payments made by the employer to discharge the employer’s liability, in accordance with the legislation.

|  |  |
| --- | --- |
| **Claim number** (if known): |  |
| **Employer Name** |  |
| **Employer number** |  |

**Name of injured worker** (family name first):

|  |  |
| --- | --- |
|  |  |

**A. Weekly Payments**:

|  |  |  |  |
| --- | --- | --- | --- |
| Number of days for which benefits have been paid:(maximum of 10 days of incapacity)  |  | Amount paid:  | $ |
| ***Specify dates*** | \_\_/\_\_/\_\_ | \_\_/\_\_/\_\_ | \_\_/\_\_/\_\_ | \_\_/\_\_/\_\_ |
| \_\_/\_\_/\_\_ | \_\_/\_\_/\_\_ | \_\_/\_\_/\_\_ | \_\_/\_\_/\_\_ | \_\_/\_\_/\_\_ | \_\_/\_\_/\_\_ |

**B. Medical & Like Expenses**

|  |
| --- |
| List details of all employer payments made for medical & like services which do not exceed the employer’s liability: |

|  |  |
| --- | --- |
| **Account Details** (name of provider): | **Amounts paid:** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **Total medical and like services payments** (maximum of **$855**\*) | **$**  |

Note: for accounts in relation to medical & like expenses, please attach copies of all accounts indicating ‘Paid’ or ‘Unpaid’ by you.
\*Current as of 1 July 2024 (amount indexed annually).

Signature of employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_\_/\_\_\_\_\_\_