Workers Compensation Commission

Matter No:

(Office use only)

FORM 7

Application for Assessment by an Approved Medical Specialist

March 2019

Application

Application for Assessment by an Approved Medical Specialist

This is the approved form to request referral for assessment of permanent impairment where there is a threshold dispute as to the degree of permanent impairment or where there is a dispute as to an employee's condition or fitness for employment.

Worker/Claimant:

Employer/Defendant:

Filed by:

☐ Worker/Claimant ☐ Insurer/scheme agent* ☐ Self-insurer

☐ Worker/Claimant representative ☐ Insurer/scheme agent representative ☐ icare

☐ Employer/Defendant ☐ Specialised insurer ☐ TMF Agent

☐ Employer/Defendant representative ☐ Industrial Relations Commission

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

This application is for:

☐ Assessment as to whether the degree of permanent impairment is more than 20%
(section 32A and/or section 59A, *Workers Compensation Act 1987*)

☐ Assessment as to whether the degree of permanent impairment is more than 30%
(section 32A, *Workers Compensation Act 1987* – worker with highest needs)

☐ Assessment as to whether the degree of permanent impairment is more than 20%
(section 39, *Workers Compensation Act 1987* – cessation of weekly payments after 5 years)

☐ Certification that incapacity is likely to be of a permanent nature
(section 53, *Workers Compensation Act 1987*)

☐ Assessment as to whether the degree of permanent impairment is more than 10%
(section 59A, *Workers Compensation Act 1987*)

☐ Threshold dispute for domestic assistance claim (section 60AA, *Workers Compensation Act 1987*)

☐ Threshold dispute for commutation of liability (section 87EA, *Workers Compensation Act 1987*)

☐ Dispute as to worker's condition and fitness for employment
(section 245, *Workers Compensation Act 1987*)

☐ Threshold dispute for work injury damages claim
(section 314, *Workplace Injury Management and Workers Compensation Act 1998*)

☐ Assessment as to whether the degree of permanent impairment is fully ascertainable
(section 319(g), *Workplace Injury Management and Workers Compensation Act 1998*)

☐ Medical dispute for bush fire fighter, emergency or rescue worker
(section 32, *Workers Compensation (Bush Fire, Emergency and Rescue Services) Act 1987*)

☐ Threshold dispute for offender in custody damages claim (section 26D, *Civil Liability Act 2002*)

NOTICE TO PARTIES

This form may only be used for assessment of the degree of permanent impairment of a worker/claimant or for assessment of an employee's condition and fitness for employment.

If this is a threshold dispute for work injury damages, evidence that a claim has been made on the insurer/defendant in accordance with the relevant State Insurance Regulatory Authority, and that the threshold dispute exists as referred to in section 314 of the 1998 Act, must be attached.

The worker/claimant must serve this application, including any attachments, on the employer/defendant involved in the threshold dispute within 7 days after this application is registered and within 7 days of service lodge a certificate certifying the date of service, the method of service, the party or other person served, and the address at which service was affected.

The parties may agree on the Approved Medical Specialist. If the parties have not agreed within 21 days from the date of registration of this application, the Registrar will choose the Approved Medical Specialist and the parties will be notified of the appointment details by written notice.

The employer/defendant must, within 21 days from the date of registration of this application, lodge and serve on the worker/claimant all documents that the employer/defendant wishes to be considered by the Approved Medical Specialist. Form 7A 'Response to an application for medical assessment' is the approved form for this purpose.

PART 1 - Medical Dispute Referred for Assessment

Complete this section only if the worker/claimant has a threshold dispute for permanent impairment

State body part(s) to be assessed as per claim made on respondent/defendant:
(Using whole person impairment terminology)

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

2.1 Has the worker/claimant been examined at any time by an Approved Medical Specialist pursuant to 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?

☐ Yes ☐ No

If yes, give the Commission matter number:

2.2 Have any proceedings in respect of lump sum compensation been taken in relation to this injury or any other injury or condition?

☐ Yes ☐ No

If yes, give the court/tribunal details and matter number(s):

2.3 Provide details of awards or settlements for lump sum compensation received in relation to this injury or any other injury or condition (Attach copies of awards/consent orders/section 66A agreements).

PART 3 – Parties Details

3.1 Worker/claimant details

Date of birth: / /

Title: ☐Mr ☐Ms ☐Mrs ☐Miss ☐Dr ☐Other

Surname/Family name: Given name(s):

Postal address: Postcode:

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 representative*

Contact person (if employer/defendant is an organisation):

Indicate language if the worker/claimant needs an interpreter:

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

3.2 Worker/claimant representative details

Firm or organisation:

Postal or DX address: Postcode:

Name of representative:

Email address:

Phone number:

3.3 Employer/defendant details

Name of business/organisation:

Postal or DX address: Postcode:

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

Contact person:

Email address:

Phone number:

3.4 Insurer/scheme agent details

Claim number:

Name of insurer/scheme agent:

Postal or DX address: Postcode:

Contact person:

Email address:

Phone number:

3.5 Insurer/scheme agent representative details

Firm or organisation:

Postal or DX address: Postcode:

Name of representative:

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 – Supporting Documentation

List all reports and medical investigation reports attached to this Application, that the worker/claimant wishes to be considered by the Approved Medical Specialist who is to assess the degree of permanent impairment.

Please note clauses 44,45 and 46 of the *Workers Compensation Regulation* 2016 for restrictions on the number of reports.

Document	Author	Date of Document
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PART 6 – Signature

Applicant/claimant's (or representative's) signature: _____ Date: / /

Lodgment Details

Lodge the original application, a copy for each party (including any insurers), plus one extra copy with the Workers Compensation Commission.

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
Facsimile	1300 368 018

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.