Workers' Compensation and Injury Management Act 1981

REQUEST FOR ASSESSMENT BY APPROVED MEDICAL SPECIALIST OF A WORKER'S DEGREE OF PERMANENT IMPAIRMENT

[section 146A(3)]

To

Name of the Approved Medical Specialist

Address

Postcode

Worker's details

Surname

Other names

Date of birth

/ /

Address

Postcode

Date of injury

/ /

Insurer claim number

Description of Injury

Contact telephone number

Email address

WorkCover WA claim number

WCCN

Employer's details

Name of organisation

Contact person

Address

Postcode	
Contact telephone number	Email address
Name of Insurer	WorkCover number (if known)

Workers' Compensation and Injury Management Act 1981

Purpose of the Assessment (Select only one below)

Workers' Compensation and Injury Management Act 1981

Schedule 2: Lump Sum Payments ☐

Assessment for the purpose of Part III Division 2A

Common Law ☐

Assessment for the purpose of Part IV Division 2 Subdivision 3

Specialised Retraining Programs ☐

Assessment for the purpose of Part IXA

Payment of Additional Medical Expenses: Exceptional Circumstances ☐

Assessment for the purpose of clause 18A of Schedule 1

Details of the Person Requesting the Assessment

Surname

Other names

Company name (if applicable)

Address

Postcode

Contact telephone number

Email address

Please make the necessary arrangement to assess degree of permanent impairment for the above worker.

Signed: _____ / /

signed by the person making the request

Date