McKinley Medical Centre

433 Police Road
Mulgrave, VIC 3170
Ph (03) 9795 4011
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WORKCOVER PERSONNEL ACKNOWLEDGEMENT FORM

Patient to complete:

I, _____ (NAME) D.O.B____/____/_____

Of _____

Postcode_____ Telephone number: _____

Medicare #:_____ Ref: ___ Exp: ___/_____

Hereby claim that on _____/_____/_____ was involved in a work-related accident. I acknowledge that in the event that my employer rejects this claim, I will be liable for all medical expenses in relation to the workplace accident.

I agree to settle all accounts at the completion of my consultation.

However, I understand that if my employer accepts the claim and completes, signs and returns the Work cover Acknowledgement Form below, to McKinley Industrial Clinic by mail or fax, I will not be liable for any of the accounts in relation to the work-related accident.

PATIENTS SIGNATURE: _____

WORKCOVER ACKNOWLEDGEMENT FORM:

Employer to complete:

Company / Agency Name _____

Department_____

Address_____

_____

Telephone No: _____

Contact Name: _____Contact Surname; _____

Position: _____

Email Address: _____Contact Number: _____

We accept full liability for all accounts in regard to the work related accident for the above employee.

Signature of Employer: _____Date: ____/____/_____

Was this Verbal Consent Yes ☐ Whom By: _____Contact Details: _____

Who will be paying for the **ACCOUNT**?

Company ☐ Agency ☐

INJURY SUSTAINED_____

Staff member who received consent_____

Staff member who filled paperwork out _____

Staff member who arrived patient _____