

**Please return this form to GAB Robbins P/L PO BOX 1438 Parramatta 2124**

## Sports Injury Report Form

Players Name											
Address								Post Code			
Date of Birth		Height		Weight		Sex	M/F	Telephone	Home	Work	
Normal occupation prior to disablement.											

### Details of Injury

**A. Give full description of injury from which you are suffering. State when, where and how it happened. (attach extra page if required)**

Type of Injury					How did Injury occur?									
Date of Injury		Time of Injury		Training	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Game	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
<b>B. 1) Have you ever had this, or a similar condition in the past?</b>											Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
2) If yes, state nature of the condition and dates of treatment and names and addresses of treating doctors, hospitals or clinics. (attach extra page if insufficient space)														
Condition (s)				Date				Treated By						

**To be completed by the Club Secretary/Treasurer - Please ensure that all questions have been fully answered**

I, .....	of	.....
<small>(Secretary/Treasurer)</small>		<small>(Name of Club)</small>
hereby certify that .....		
<small>(Player's Name)</small>		
sustained the injuries resulting in this		
claim on .....	at .....	am/pm, whilst playing/training for .....
<small>(Date)</small>	<small>(Time)</small>	<small>(Team)</small>
against .....	at .....	.....
<small>(Opposition Team)</small>	<small>(Place of Game)</small>	
Signed: .....		
<small>(Secretary/Treasurer)</small>	<small>(Date)</small>	
Club Mailing Address: .....		
Telephone: .....		

**To be completed by the Association - Please ensure that all questions have been fully answered**

I, .....	of	.....
<small>(Association Official)</small>		<small>(Name of Association)</small>
hereby certify that .....		
<small>(Player's Name)</small>		
is a registered member of the		
abovementioned Association and I hereby sign this form in acknowledgement of the claim being made.		
Signed: .....		
<small>(Association Official)</small>	<small>(Date)</small>	

**To be completed by player (parent / guardian if under 18 years)**

I hereby authorise any hospital, physician or other person who has attended to me, or any employer, to furnish QBE Insurance (Australia) Limited, or its representatives, any and all information with respect to any sickness or injury, medical history, consultations, prescriptions, or treatment, copies of all hospital or medical records and copies of all records of employers. I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I agree that if I have made or in any further declaration in respect of the said injury or sickness shall make any fraudulent statements or conceal or suppress, or falsely state any material fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past or future injuries or sickness shall be forfeited.

Signature		Date	
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When did you first consult a physician for this condition?	
When did you become totally disabled (unable to work)?	
When were you able to again perform part of your occupational duties?	
If still totally disabled, when do you expect your disability to terminate?	
When will you resume training?	

**Non Medicare Medical Expenses**

Are you a member of a private health fund?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, which one?		
Hospital Cover	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Extras covering dental/physio etc	Yes <input type="checkbox"/>	No <input type="checkbox"/>

*NB Only forward accounts for services which are not subject to a Medicare rebate ie. Physiotherapy, Chiropractic, Ambulance, Private Hospitals, Dental etc.*

Date of Treatment	Name of Provider	Type of Service	Amount	Health Fund Rebate	Amount Claimed
a)					
b)					
c)					
d)					

<b>Give name and address and period of stay at hospital:</b>			
Name	Addresses	From	To
<b>Give name and address and telephone numbers of all attending physicians. (attach extra page if insufficient space)</b>			
Name	Address	Telephone	
<b>Give name and address and telephone numbers of usual family physicians. (attach extra page if insufficient space)</b>			
Name	Address	Telephone	

**Loss of Income Claims**

Are you entitled to receive compensation from any other source for this injury?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please provide details?		

**If self-employed** (Please attach proof of earnings over past 12 months eg. Tax Return)

Name of Accountant	Address	Telephone

**If employed as a wage earner** (To be completed by your employer)

I HEREBY CERTIFY THAT: ..... has been unable to attend his/her usual occupation with the Company as a result of an injury/injuries suffered on: .....

He/She has been incapacitated since: ..... and is expected to/did resume duties on: .....

His/Her gross basic salary (excluding bonuses, commission and overtime) at the date of injury was \$ ..... per week

During the period of incapacity he/she received:

a) Normal pay: \$ ..... b) Sick Pay: \$ ..... c) Workers Compensation: \$ .....

From ..... to ..... From ..... to ..... From ..... to .....

He/She has been employed since: ..... Company Stamp:

His/Her sick leave entitlements at date of injury is: ..... days

Name of Company: .....

Address: .....

Name of Supervisor or Paymaster (Please Print): .....

Signature..... Date: .....

Telephone No.....

## Attending Physicians Statement

(The insured is responsible for completion of this form without expense to the company)

Patients Name		Address		Sex	M/F
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<i>What is disabling patient? (Please give a complete diagnosis of this condition)</i>

### **History**

1. When did patient first receive medical treatment?	
2. Was there a previous history of this or a similar condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>If yes, please state condition and advise when previous treatment given.</i>	
3. a) How long have you known the patient?	
b) Are you the regular general practitioner? If no please advise who is?	Yes <input type="checkbox"/> No <input type="checkbox"/>

### **If Injury**

1. When did patient suffer the injury?	
2. What were the circumstances surrounding the injury?	

### **If Disability**

1. Patients occupation?	
2. When was patient obliged to cease work?	
3. If patient still disabled, when approximately will the patient be able to resume.	
a) some duties	b) full duties
4. If patient has recovered, when was patient able to resume.	
a) some duties	b) full duties

### **Treatment of Present Condition**

1. When were you consulted?
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a) initially?		b) most recently?	
2. How often has patient consulted you?			
3. Was patient confined to hospital? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes please advise Hospital Name			
Address			
Period of confinement		From	To
4. Was confinement in a convalescent home necessary after hospitalisation? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes please give details.			
5. What are the current subjective symptoms.			
6. Please give results of any objective finding.			
a) X-rays			
b) Other test - Please advise test done and findings			
7. What surgical procedures have been performed?			
8. What surgical procedures have been contemplated?			
9. What other treatment has the patient undergone?			
10. What other treatment is required?			
Are there any underlying conditions affecting recovery from the current condition? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes please advise nature of underlying conditions and how they affect disability and recovery.			
Has patient any other physical or mental impairment? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes, please describe.			
Please advise names and addresses of other treating physicians.			
Name		Address	Telephone
If you have terminated treatment, please advise date.			
What is your current prognosis?			
Are there any further remarks which may assist in assessing this condition?			
Is there any permanent disability present? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes, please explain giving estimated percentage of loss of function.			
Name (please print name)		Address	Telephone
Signature		Degree	Date