



This form is to be used to report an incident or submit an insurance claim, when a third party alleges a participant has been negligent and has caused injury or property damage. Send a completed copy of the Incident Report to the Department of Employment and Workplace Relations through the [InsuranceandIncidents@dewr.gov.au](mailto:InsuranceandIncidents@dewr.gov.au) mailbox and your Provider Lead.

**Has this incident been reported to the State WHS regulator:**      Yes      No      Not applicable

**Please advise the program/activity type being undertaken:**

**REMEMBER:** Under no circumstances should you admit Liability or enter into any discussion correspondence in connection with any incident that could result in a claim being made against your policy.

### Information about participant

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**Job Seeker ID:**      **Date of birth (dd/mm/yyyy):**

**Full name:**

**Address:**

**Email:**      **Phone:**

### Information about the incident

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**Activity ID:**      **Name of Activity:**

**Date of Incident (dd/mm/yyyy):**      **Time of Incident:**

**Address/Location of Incident:**

**Description of Incident (what happened, how did it happen, any factors leading to the incident).  
Please be as specific as possible:**

**Was there any property damage? – if so please describe:**

**Were there any witnesses to the incident:**      Yes      No

**If yes, please list names and telephone numbers for each witness:**

**Was the incident reported to the Police?:**      Yes      No

## Provider information

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Name of Provider organisation:

Is this the name of the lead provider:      Yes      No

If no, please list the Lead Provider name:

All the information that I have given in this Claim Form/Incident Report is true and complete:      Yes      No

Name of Person completing the form:

Signature of person completing the form:                      Date (dd/mm/yyyy)

## Host organisation information

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Name of host organisation:

Address:

Supervisor name:

**PLEASE NOTE: Where applicable, this form will be used as the claim form for insurance purposes. To ensure the claim can be appropriately processed, the job seeker/participant signature is required.**

## Participant declaration

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All information that I have given in this Claim Form/Incident Report is true and complete.

Name of Participant:

Signature Signature of Participant:                      Date (dd/mm/yyyy)