



# APPLICATION FORM - WORKER HEALTH CHECKS

July 2009

All fields are mandatory

## Things you need to do before lodging this form:

- Read the Worker Health Check guidelines available on [workhealth.vic.gov.au](http://workhealth.vic.gov.au).
- Make sure that all information provided is accurate.
- Read the terms and conditions provided in the Funding Agreement.
- Complete the Declaration section of the Application Form.

## How will the information collected be used?

Information collected will be used for processing and administering Worker Health Checks. It may also be used for evaluating the Worker Health Check program.

WorkSafe Victoria (WorkSafe) may disclose information collected on this form to its contractors and agents and any person or organisation authorised by you, or by law, to obtain it.

Applicants should note that all information submitted to WorkSafe may be the subject of a request under the *Freedom of Information Act 1982 (Vic)*. WorkSafe will consult with an employer if a request relates to that organisation's commercial information.

## For help filling out this form

If you need help filling out this form, contact WorkSafe on 1800 136 089.

## How to submit this form

**Mail:** WorkHealth  
WorkSafe Victoria  
GPO Box 4306  
Melbourne VIC 3001

**Facsimile:** (03) 9641 1952

## Section 1 – Contact Information

### Part A: Employer Details

Legal Name of Employer

Business / Trading Name

Main Street Address

Town / Suburb

Postcode

State

Postal Address (if different from above)

Town / Suburb

Postcode

State

Type of Organisation  Company (registered under Corporations Act)  Partnership  Trustee

Other (please specify)

Annual Rateable Remuneration for the organisation (Australia wide):

Total Number of Workers (including part time and contract workers, trainees and apprentices) in Victoria:

*This will assist us to determine the maximum funding available to your organisation.*

Australian Business Number (ABN)

Are you registered for GST?

 Yes

 No

WorkSafe Injury Insurance Number (Employer number) *You must provide either your WorkSafe Injury Insurance Number or indicate that you manage your workers compensation claims as a self insurer.*

**OR** Self Insured Organisation

### Part B: Employer Contact Details

**Applicant Representative** *This is the individual with authority to apply. All correspondence will be addressed to this person.*

Title First Name



Last Name

Position Title

Telephone

Mobile

Fax

Email

Does your organisation agree to be contacted by WorkHealth or an agent of WorkHealth to participate in future evaluations (estimated at no more than 20 minutes)?

 Yes

 No

## Section 1 – Contact Information (cont.)

### Part C: Employer Payment Details

This information is required in order for WorkSafe to reimburse you for all or part of the costs incurred in obtaining worker health checks.

Do you wish WorkSafe to reimburse your organisation by electronic funds transfer (EFT)?

YES - please advise of your banking details below.

NO - WorkSafe will forward a cheque reimbursement to your organisation.

Bank Name

Bank Account Name (Payee Name)

Branch Number / Banks BSB

Bank Account Number (Payee Account Number)

## Section 2 – Nominated Worksites

Please provide details of all the worksites that will receive worker health checks. If the worker health checks are across multiple locations, please complete and attach the WorkHealth Location Template. This template can be found at the WorkHealth website: [workhealth.vic.gov.au](http://workhealth.vic.gov.au).

Worksite - Address

Town/Suburb

Postcode

Local Government Area

Total Number of Workers (including part time and contract workers, trainees and apprentices) at this Worksite

Expected Number of Participating Workers at this Worksite

## Section 3 – Preferred Endorsed Service Provider

You will be contacted by either a suitable endorsed service provider, or a WorkSafe representative who will assist with the selection of an endorsed service provider.

Alternatively, if your organisation has been contacted by a prospective endorsed service provider and you wish to nominate them please enter their promotional code:

Provider Number 1015 - Nabenet Health

If you have any questions please call 1800 136 089.

## Declaration

In submitting this application, all signatories to this application 1) accept the terms and conditions of the Funding Agreement for the Worker Health Check program and 2) declare that the information contained in the application, including all attachments, is to the best of their knowledge true, accurate and complete.

Signature (Your signature confirms that you have accepted the above declaration.)

Print Name

Position Title

Date

(To be completed by the Applicant Representative)

## Supporting Documents

Please provide details of any documents attached to the application.

WorkHealth Location Template (only if required – refer to Section 2 of this form).

## OFFICE USE ONLY

Application Identification Number

Administration Officer Name

Date Received

Date Processed

Acquittal Date