# FORM 2

# PERSONAL INJURIES PROCEEDINGS ACT 2002

## NOTICE OF CLAIM
## (Health Care Claims)

## INSTRUCTIONS FOR COMPLETING THIS FORM ARE ATTACHED AS THE LAST THREE PAGES OF THE FORM

***PLEASE READ INSTRUCTIONS CAREFULLY***

***THERE ARE TWO PARTS TO THIS FORM***

***PART 1 AND PART 2 ARE TO BE GIVEN AT DIFFERENT TIMES***

**This Notice of Claim has been approved by the Department of Justice and Attorney-General and questions etc. should not be altered in any way**

**Version 5**

# NOTICE OF CLAIM
# (Health Care Claims)

## PART 1
**(Comprising Sections A, B, C and D)**

To: _____

_____

_____

_____

*(Respondent/s – Name/s and Address/es)*

## NOTICE TO RESPONDENT

Within one (1) month after receiving this Part 1 Notice, you must:

(a) if you consider yourself a proper respondent to the claim, give the claimant written notice of whether you are satisfied that the Part 1 Notice of Claim is a complying Part 1 Notice of Claim and if not, give details of non-compliance and whether you waive that non-compliance. If you do not waive non-compliance, you must specify a reasonable period of at least 1 month for the claimant to remedy the non-compliance;

(b) if you are unsure whether you are a proper respondent to the claim, give the claimant written notice of the further information you reasonably need to decide whether you are a proper respondent; or

(c) if you consider that you are not a proper respondent to the claim, give the claimant written notice of the reasons why you consider that you are not a proper respondent to the claim and any information you have that may help the claimant identify a proper respondent to the claim.

In any of the above responses, you should provide the claimant with the name and telephone number of a contact person who will be dealing with the claim.

# HEALTH CARE CLAIM

**[Section A]**

***Initial Claim Details***

## 1. INJURED PERSON'S PERSONAL DETAILS

Surname/Family Name: _____

Given Names: _____

Title: ☐ Mr ☐ Ms ☐ Mrs ☐ Miss ☐ Other

Date of Birth: _____ *(insert day/month/year)*

Gender: ☐ Male ☐ Female

Home Address: _____

_____ Postcode: _____

Postal Address (*if different than above*): _____

_____ Postcode: _____

Home Telephone Number: (____) _____

## 2. HAS THE INJURED PERSON EVER BEEN KNOWN BY ANY OTHER NAME?

☐ No ☐ Yes

If 'Yes', provide in full, all other names the person has been known as:

_____

_____

## 3. DOES THE INJURED PERSON NEED AN INTERPRETER?

☐ No ☐ Yes

If 'Yes', which language will the interpreter need to be fluent in?

_____

**4. HAS THE INJURED PERSON INSTRUCTED A LAW PRACTICE TO ACT ON THE PERSON'S BEHALF IN SEEKING DAMAGES FOR THE PERSONAL INJURY?**

☐ No ☐ Yes

If 'Yes', provide date of consultation: _____

Name of Lawyer and Firm: _____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

**5. HAS THE INJURED PERSON GIVEN, OR DO THEY INTEND TO GIVE, NOTICES OF CLAIM TO ANY OTHER PERSON IN RELATION TO THE INCIDENT?**

☐ No ☐ Yes

If yes, give full details of the names and addresses of each other person to whom they have given or intend to give a Notice of Claim:

(i) _____

(ii) _____

(iii) _____

(iv) _____

**6. IS THE STATE OF QUEENSLAND THE RESPONDENT NAMED IN THIS NOTICE OF CLAIM?**

☐ No ☐ Yes

If Yes, which is the government department you believe to be responsible?

_____

**[Section B]**

## THE INCIDENT

### 7. GENERAL DETAILS

Date of Incident: _____ *(insert day/month/year)*

Time of Incident: ____ ☐ am ____ ☐ pm

Place where the incident occurred (hospital or other facility or, where applicable, street and town or suburb) _____

### 8. HAS THE INJURED PERSON MADE A COMPLAINT ABOUT THE PERSON WHOM THEY BELIEVE CAUSED THE INCIDENT TO THE HEALTH RIGHTS COMMISSION?

☐ No *(if no, tick and go to Q9)* ☐ Yes

(a) Give the date the complaint was made to the Commission: _____

(b) Has the complaint been finalised under the *Health Rights Commission Act 1991?* ☐ No ☐ Yes

If 'Yes', give details of how the complaint was dealt with under that Act:

_____

_____

_____

Date the complaint was finalised: _____

### 9. GIVE A BRIEF DESCRIPTION OF THE INCIDENT

_____

_____

_____

_____

_____

_____

_____

**10. IN THE 12 HOURS BEFORE THE INCIDENT, HAD THE INJURED PERSON TAKEN ANY DRUGS (INCLUDING MEDICATION) OTHER THAN THOSE PRESCRIBED OR ADMINISTERED FOR THE PURPOSES OF RECEIVING THE TREATMENT THAT FORMS THE BASIS FOR THIS HEALTH CARE CLAIM?**

☐ No ☐ Yes

What drugs were taken?: _____ *(insert type)*

_____ *(insert amount)* _____ *(insert when)*

**11. HAD THE INJURED PERSON CONSUMED ANY ALCOHOL IN THE 12 HOURS BEFORE THE INCIDENT?**

☐ No ☐ Yes

What drinks were consumed? _____ *(insert type)*

_____ *(insert amount)* _____ *(insert when)*

**12. WITNESSES**

Give Details of Witnesses:

**Witness 1:**
Surname/Family Name: _____

Given Name: _____

Home Address: _____

_____ Postcode: _____

Contact Telephone Number: (_____) _____

**Witness 2:**
Surname/Family Name: _____

Given Name: _____

Home Address: _____

_____ Postcode: _____

Contact Telephone Number: (_____) _____

**(Note: If more than two witnesses, write the details on a separate page labelled 'Witnesses' and attach it to this form)**

**13. DETAILS OF THE PERSON(S) THAT CAUSED THE INCIDENT.**

Surname/Family Name: _____

Given Name: _____

Home Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

**14. DETAIL THE REASONS WHY THE INJURED PERSON BELIEVES THAT PERSON CAUSED THE INCIDENT**

The reasons must particularly identify the step, process or act/s of the person that caused the incident and the link to the named respondent (if different to the person named in response to Q13): _____

_____

_____

_____

_____

_____

**(Note: If more than one person caused the incident, please write details and <u>reasons</u> on a separate page labelled, 'Persons that caused the incident' and attach it to this form.)**

**15. DOES THE INJURED PERSON ALLEGE THAT THE CLAIM RELATES TO OR INCLUDES AN ALLEGED FAILURE OF THE HEALTH CARE PROVIDER TO INFORM OR ADEQUATELY INFORM THE INJURED PERSON OF THE RISKS INVOLVED IN THE TREATMENT SOUGHT?**

☐ No *(if no, tick and go to Q16)* ☐ Yes ☐ Don't know

(i) If yes, provide the date, time and place of each consultation with the health care provider in which a warning should have been given:

_____

_____

(ii) If the health care provider did provide any advice or a warning about the treatment, in relation to <u>each instance</u> where such advice or warning was given, identify –

- Whether that advice or warning was given orally or in writing?

_____

_____

- The date and place where each advice or warning was given?

_____

_____

- Details of the warning given, including what you were warned about?

_____

_____

(iii) What were the risks about which it is alleged the injured person should have been informed or adequately informed by the health care provider?

_____

_____

**16. WAS WRITTEN OR ORAL CONSENT GIVEN BY THE INJURED PERSON TO THE HEALTH CARE PROVIDER ABOUT THE TREATMENT?**

☐No

☐Yes _____ *(insert date)* _____ *(insert time)*

_____ *(insert place)*

_____

_____

_____

*(insert details of the consent)*

**17. DESCRIBE THE MEDICAL CONDITION FOR WHICH THE INJURED PERSON SOUGHT TREATMENT:**

_____

_____

**18. DESCRIBE THE NATURE, TYPE AND SEVERITY OF THE SYMPTOMS CLAIMED TO HAVE ARISEN FROM THE TREATMENT:**

_____

_____

**[Section C]**

## THE INJURIES AND HEALTH DETAILS

**19. PROVIDE THE NAMES, ADDRESSES AND TELEPHONE NUMBERS OF ALL HEALTH CARE PROVIDERS WHO TREATED THE INJURED PERSON FOR THE MEDICAL CONDITION FOR WHICH TREATMENT WAS SOUGHT DURING THE THREE (3) YEARS PRIOR TO THE INCIDENT.**

**Provider 1:**

Surname/Family Name: _____

Given Name: _____

Contact Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

Was a written report provided?: ☐ No ☐ Yes

**Provider 2:**

Surname/Family Name: _____

Given Name: _____

Contact Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

Was a written report provided?: ☐ No ☐ Yes

**Provider 3:**

Surname/Family Name: _____

Given Name: _____

Contact Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

Was a written report provided?: ☐ No ☐ Yes

**Provider 4:**

Surname/Family Name: _____

Given Name: _____

Contact Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

Was a written report provided?: ☐ No ☐ Yes

**(Note: If more than four providers were involved in the incident, please write details on a separate page labelled, 'Health Care Providers prior to the Incident' and attach it to this form.)**

**20. DESCRIBE WHAT ASPECT OF THE TREATMENT IS BEING COMPLAINED OF AS CAUSING THE INJURY OR AGGRAVATION OF A PRE-EXISTING INJURY OR CONDITION:** _____

_____

_____

_____

**21. PROVIDE NAMES, ADDRESSES AND TELEPHONE NUMBERS OF ALL PERSONS WHO HAVE PROVIDED THE INJURED PERSON WITH INFORMATION OR EXPLANATIONS ABOUT THE INJURY OR AGGRAVATION OF A PRE-EXISTING INJURY OR CONDITION.**

**Person 1:**

Surname/Family Name: _____

Given Name: _____

Contact Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

Was a written report provided?: ☐ No ☐ Yes

**Person 2:**

Surname/Family Name: _____

Given Name: _____

Contact Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

Was a written report provided?: ☐ No ☐ Yes

**Person 3:**

Surname/Family Name: _____

Given Name: _____

Contact Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

Was a written report provided?: ☐ No ☐ Yes

**Person 4:**

Surname/Family Name: _____

Given Name: _____

Contact Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

Was a written report provided?: ☐ No ☐ Yes

**(Note: If more than four persons have provided information or explanations, please write details on a separate page labelled, 'Persons Providing Information or Explanation' and attach it to this form.)**

## 22. WHAT INJURIES DID THE INJURED PERSON SUSTAIN IN THE INCIDENT?

List all injuries: _____

_____

_____

_____

_____

## 23. WHO HAS TREATED THE INJURED PERSON FOR THEIR INJURIES AND WHAT TREATMENT HAS BEEN PROVIDED?

List all health care providers, eg doctors, surgeons, physiotherapists, chiropractors and fully detail the treatment provided (eg. surgical placement of pins; psychiatric assessment; etc)

**Provider 1:**

Occupation: _____

Name (practice or surgery): _____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Nature of Treatment: _____

Was a written report provided?: ☐ No ☐ Yes

**Provider 2:**
Occupation: _____

Name (practice or surgery) : _____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Nature of Treatment: _____

Was a written report provided?: ☐ No ☐ Yes

**Provider 3:**
Occupation: _____

Name (practice or surgery) : _____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Nature of Treatment: _____

Was a written report provided?: ☐ No ☐ Yes

**(Note: If not enough space, write details on a separate page labelled 'Health Care Providers etc' and attach it to this form.)**

**24. HAS THE INJURED PERSON SUFFERED ANY DISABILITIES FROM THE PERSONAL INJURY (eg limp, restricted movement, impaired vision) WHICH IS RELEVANT TO THE ASSESSMENT OF THE EXTENT OF THE PERSONAL INJURY?**

☐ No *(if no, tick and go to Q25)* ☐ Yes

If 'Yes', describe the disabilities: _____

_____

_____

_____

**(Note: If more space is required to answer this question, write the details on a separate page labelled 'Disabilities' and attach it to this form.)**

**25. HAS THE INJURED PERSON EVER MADE A CLAIM EITHER BEFORE OR SINCE THE INCIDENT IN RELATION TO THIS OR ANY OTHER INCIDENT FOR DAMAGES, COMPENSATION OR SOCIAL SECURITY BENEFITS RESULTING FROM PERSONAL INJURIES, ILLNESSES OR DISABILITIES?**

☐ No ☐ Yes Date: _____ *(insert day/month/year)*

Against whom was the claim made?

Name: _____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Name of Insurer:_____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Claim Reference No.: _____

Type of Claim (eg Workers' Compensation): _____

_____

**(NOTE: If the injured person has made more than one claim, write details on a separate page labelled 'Previous claims' and attach it to this form.)**

**[Section D]**

## DOCUMENTS THAT SHOULD BE ATTACHED TO THIS FORM

**Please attach a copy of each the following to the rear of this form:**
**(please tick if attached)**

- ❑ **medical reports or certificates relating to injuries suffered in the incident**
- ❑ **medical reports relating to the history of the injured person**
- ❑ **reports generally relating to the incident and its causes**

## DECLARATION AND AUTHORISATION

You must have completed all of the information required in this Part 1 Notice of Claim and it must be declared before a Justice of the Peace or Solicitor.

The form must be signed by the injured person unless he/she is under 18 or is unable to complete it. In these cases it must be completed by a parent, guardian, relative or friend of the injured person.

**You <u>must</u> also give your written permission to allow the respondent or their insurer to obtain any records or information that may affect your claim from:**

- The insurers;
- A department, agency or instrumentality of the Commonwealth, the State or another State administering police, transport, taxation or social welfare laws;
- A hospital;
- The ambulance or other emergency service of the State or another State;
- A doctor or other health-care provider;
- An educational institution;
- An employer (or previous employer).

**Under Section 73 of the *Personal Injuries Proceedings Act 2002* you can be fined up to $11,250 or be imprisoned for up to one (1) year for knowingly providing false, misleading or incomplete particulars in this form. Therefore, all the information you have given in the Notice of Claim must be true, correct and complete.**

## Claimant's Declaration and Authorisation

I hereby authorise the respondent against whom this claim is made or their insurer to contact those persons and entities mentioned within this Part 1 Notice of claim and to obtain information and documents relevant to the claim.

I do solemnly and sincerely declare that the statements of fact contained in this Part 1 Notice of Claim (Health Care Claim) (including the attached pages) are true, correct and complete in every respect and I make this declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1867*.

_____

**(Signature)**

TAKEN AND DECLARED BEFORE ME: _____

**(Signature of Justice of the Peace or Solicitor)**

ON: _____ / _____ / _____

AT (*plac*e): _____

Justice of the Peace or Solicitor's Name: _____

Address: _____

Injured Person's Surname/Family Name:_____

Given Names: _____

**IF ANOTHER PERSON SIGNED ON BEHALF OF THE INJURED PERSON:**

Give Details of the Person who Signed the Form:

Person's Surname/Family Name:_____

Given Names: _____

Address: _____

_____

Home Telephone Number: (_____) _____

Relationship to the Injured Person: _____

Reason/s why the injured person could not sign: _____

# NOTICE OF CLAIM
# (Health Care Claims)

## PART 2
**(Comprising Sections E, F, G and H)**

To: _____

_____

_____

_____

*(Respondent/s – Name/s and Address/es)*

From: _____

_____

_____

_____

*(Claimant)*

**[Section E]**

## ECONOMIC LOSS

**NOTE: Questions 26–45 ask you about any loss of income to the injured person as result of the incident. The injured person may have suffered loss of income to their business or from their employment or a combination of both. Read the questions and 'go to' instructions carefully.**

### 26. WHAT WAS THE INJURED PERSON'S EMPLOYMENT SITUATION BEFORE THE INCIDENT?

| | | | |
|---|---|---|---|
| ☐ | Self-employed | ☐ | Retired |
| ☐ | Home duties | ☐ | Student |
| ☐ | Employed | ☐ | Other *(please describe)* |
| ☐ | Unemployed | | _____ |

Usual Occupation: _____

Was the injured person employed as at the date of the incident?

☐ No ☐ Yes

Nature of Employment: _____

_____ *(insert details)*

### 27. HAS THE INJURED PERSON LOST OR WILL THE INJURED PERSON LOSE WAGES, SALARY OR BUSINESS INCOME BECAUSE OF THE INCIDENT?

☐ No *(if no, tick and go to Q47)* ☐ Yes

### 28. IS THE INJURED PERSON STILL LOSING INCOME?

☐ No ☐ Yes

### 29. HAS THE INJURED PERSON RETURNED TO WORK AT ALL SINCE THE ACCIDENT?

☐ No ☐ Yes *(if yes, tick and go to Q31)*

### 30. WHEN DOES THE INJURED PERSON EXPECT TO RETURN TO WORK?

Date: _____ *(insert day/month/year)* OR

☐ Don't know OR

☐ Unable to return to work

## 31. INJURED PERSON'S EDUCATIONAL DETAILS

Names of educational institutions attended by the injured person:

(i) _____

(ii) _____

(iii) _____

(iv) _____

## 32. LIST HERE PARTICULARS OF THE INJURED PERSON'S EMPLOYMENT DURING THE THREE YEARS PRIOR TO THE INCIDENT AND THE PERIOD SINCE THE INCIDENT *(if self-employed see below.) (Attach additional information on a separate page if required.)*

Name of Employer:_____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Period of Employment: _____

Capacity in which Employed: _____

Earnings for Period: _____

**Self Employed Details:** ***(if applicable)***

Nature of Self-employment: _____

Period of Self-employed: _____

Gross Earnings per year: _____

Net Earnings per year: _____

Name of Business:_____

Nature of Business: _____

Address (Workplace): _____

_____ Postcode: _____

Telephone Number: (____) _____

**33. DOES THE INJURED PERSON USE AN ACCOUNTANT IN PREPARATION OF TAXATION RETURNS, BUSINESS STATEMENTS OR SIMILAR FINANCIAL DOCUMENTS?**

Accountant's Name: _____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

**34. HOW MANY SEPARATE PERIODS OF TIME HAS THE INJURED PERSON BEEN AWAY FROM WORK BECAUSE OF THE INCIDENT?** (include short periods when they went for treatment)

**Separate Periods:**

**First** (or only)Period: _____

Work Time Lost:_____ (*insert hours/days/weeks)*

From (or on): _____ (*insert day/month/year)*

To: _____ (*insert day/month/year)*

**Second Period** *(if applicable)*: _____

Work Time Lost:_____ (*insert hours/days/weeks)*

From (or on): _____ (*insert day/month/year)*

To: _____ (*insert day/month/year)*

**Third Period** *(if applicable)*: _____

Work Time Lost:_____ (*insert hours/days/weeks)*

From (or on): _____ (*insert day/month/year)*

To: _____ (*insert day/month/year)*

**Fourth Period** *(if applicable)*: _____

Work Time Lost:_____ (*insert hours/days/weeks)*

From (or on): _____ (*insert day/month/year)*

To: _____ (*insert day/month/year)*

**(Note: If the injured person had more than four separate periods away from work, write details on a separate page labelled 'Periods Away from Work' and attach it to this form.)**

**35. IS THE WORK THE INJURED PERSON DOES OR THEIR WEEKLY EARNINGS DIFFERENT BECAUSE OF THE INCIDENT?**

☐ No ☐ Yes

Give Details: _____

_____

**36. HAS THE INJURED PERSON LOST INCOME FROM SELF-EMPLOYMENT IN THEIR OWN BUSINESS BECAUSE OF THE INCIDENT?**

☐ No *(if no, tick and go to Q39)* ☐ Yes

**37. ESTIMATED EARNINGS LOST**

Give details of how much it is believed the injured person has lost **through self-employment** and how the amount is calculated. *(Copies of the injured person's taxation returns must be provided to the respondent.)*

_____

_____

_____

**(Note: If necessary, write details on a separate page labelled 'Self Employment Earnings Lost' and attach it to this form.)**

**38. IS THE BUSINESS STILL OPERATING?**

☐ No ☐ Yes

**39. HAS ANYONE BEEN HIRED TO REPLACE THE INJURED PERSON?**

☐ No Explain why not: _____

_____

☐ Yes Give details of replacement:

Name:_____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Duties Performed: _____

Cost: _____

**(Note: If necessary, write details on a separate page labelled 'Self Employment – Replacement' and attach it to this form.)**

**40. HAS THE INJURED PERSON LOST WAGES OR SALARY, AS AN EMPLOYEE, BECAUSE OF THE INCIDENT?**

☐ No *(if no, tick and go to Q43)* ☐ Yes

**41. EMPLOYMENT DETAILS**

Employment Details:_____

Occupation: _____

Name of Employer (Company or Organisation): _____

_____

Address (Workplace): _____

_____ Postcode: _____

Telephone Number: (____) _____

Contact Person's Name: _____

Usual **Weekly** Working hours: _____ (ordinary) _____ (overtime)

Description of Duties: _____

Standard Weekly Earnings: _____ *(insert Gross Pay)*

_____ *(insert Tax amount)*

_____ *(insert Net Pay)*

**42. DID THE INJURED PERSON HAVE A SECOND PAID JOB BEFORE THE INCIDENT?**

☐ No *(if no, tick and got to Q43)* ☐ Yes

**43. EMPLOYMENT DETAILS – SECOND JOB**

**Second Job:**

Employment Details:_____

Occupation: _____

Name of Employer (Company or Organisation): _____

_____

Address (Workplace): _____

_____ Postcode: _____

Telephone Number: (____) _____

Contact Person's Name: _____

Usual **Weekly** Working hours: _____ (ordinary) _____ (overtime)

Description of Duties: _____

Standard Weekly Earnings: _____ *(insert Gross Pay)*

_____ *(insert Tax amount)*

_____ *(insert Net Pay)*

**44. BEFORE THE INCIDENT, HAD THE INJURED PERSON MADE ANY FIRM ARRANGEMENTS TO START A NEW JOB, OR STOP WORK, OR CHANGE THEIR DUTIES, WORKING HOURS, OR EARNINGS?**

☐ No ☐ Yes

Give Details: _____

_____

**45. PROVIDE A STATEMENT OF THE NATURE AND EXTENT OF THE INJURED PERSON'S ECONOMIC LOSS**
*(as far as it can be assessed at the date of lodging their notice of claim)*

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**46. HAS THE INJURED PERSON RECEIVED, OR WILL THEY RECEIVE ANY MONEY, FOR BEING UNABLE TO WORK BECAUSE OF THEIR INJURIES?** *(e.g., sick leave or holiday pay, social security benefits, workers' compensation, borrowed money or insurance payment.*)

☐ No ☐ Yes

Give Full Details: _____

_____

If the injured person:

(a) received a benefit provide their social security number: _____

(b) received workers' compensation, provide the insurer's details and claim number:

Name:_____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Claim Number: _____

(c) borrowed money, provide the lender's details:

Name:_____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

(d) received a payment from an insurance company, provide the name and address of the insurer and the policy number.

Name:_____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Policy Number: _____

**[Section F]**

## FURTHER HEALTH DETAILS

**47. PROVIDE DETAILS OF ALL PERSONS WHO HAVE PROVIDED THE INJURED PERSON WITH INFORMATION OR EXPLANATIONS ABOUT THE INJURY SINCE DELIVERING PART 1 OF THE NOTICE.**

**Person 1:**

Surname/Family Name: _____

Given Name: _____

Contact Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

Was a written report provided?: ☐ No ☐ Yes

**Person 2:**

Surname/Family Name: _____

Given Name: _____

Contact Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

Was a written report provided?: ☐ No ☐ Yes

**Person 3:**

Surname/Family Name: _____

Given Name: _____

Contact Address: _____

_____ Postcode: _____

Contact Telephone Number: (____) _____

Was a written report provided?: ☐ No ☐ Yes

**(Note: If more than three persons have provided information or explanations, please write details on a separate page labelled, 'Persons Providing Information or Explanation' and attach it to this form.)**

**48. WHO HAS TREATED THE INJURED PERSON SINCE DELIVERY OF PART 1 OF THE NOTICE AND WHAT TREATMENT HAS BEEN PROVIDED?**

List all health care providers, eg doctors, surgeons, physiotherapists, chiropractors that treated the injured person after delivery of Part 1 of the notice and detail the treatment provided (eg. surgical placement of pins; psychiatric assessment; etc)

**Provider 1:**

Occupation: _____

Name (practice or surgery): _____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Nature of Treatment: _____

Was a written report provided?: ☐ No ☐ Yes

**Provider 2:**

Occupation: _____

Name (practice or surgery) : _____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Nature of Treatment: _____

Was a written report provided?: ☐ No ☐ Yes

**Provider 3:**

Occupation: _____

Name (practice or surgery) : _____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

Nature of Treatment: _____

Was a written report provided?: ☐ No ☐ Yes

**(Note: If not enough space, write details on a separate page labelled 'Health Care Providers etc' and attach it to this form.)**

**49. HAS REHABILITATION BEEN RECOMMENDED FOR THE INJURED PERSON? (e.g. counselling, group therapy, work training, independent living assistance, exercise program)**

☐ No ☐ Yes

What has been recommended: _____

_____

_____

**50. HAS A REHABILITATION PLAN BEEN DEVELOPED FOR THE PERSON?**

☐ No ☐ Yes

**51. HAS THE INJURED PERSON STARTED REHABILITATION?**

☐ No ☐ Yes

What rehabilitation has the injured person had: _____

_____

_____

**52. WHO IS PROVIDING THE REHABILITATION SERVICES?**

Name: _____

Occupation: _____

Address: _____

_____ Postcode: _____

Telephone Number: (____) _____

**53. DOES THE INJURED PERSON PLAN TO CONTINUE WITH REHABILITATION?**

☐ No ☐ Yes

What rehabilitation will the injured person have: _____

_____

_____

**[Section G]**

## OFFER OF SETTLEMENT

**54. AT THIS STAGE, IS THE INJURED PERSON IN A POSITION TO MAKE AN OFFER FOR THE SETTLEMENT OF THEIR CLAIM?**

☐ No - Provide the reason/s why an offer of settlement cannot be made:

_____

_____

_____

☐ Yes - Provide full details of the basis of the offer of settlement:

_____

_____

_____

**NOTE: An offer of settlement must be accompanied by a copy of medical reports, assessments of cognitive, functional or vocational capacity, or other material in their possession that may assist the respondent to make a proper assessment of the offer.**

**[Section H]**

## DOCUMENTS THAT SHOULD BE ATTACHED TO THIS FORM

**Please attach a copy of each the following to the rear of this form:**
**(please tick if attached)**

- ❑ **taxation returns of the injured person (for the three years prior to the incident)**
- ❑ **medical reports relating to injuries suffered in the incident**
- ❑ **reports and documents not provided with Part 1 of the Notice**

## DECLARATION AND AUTHORISATION

You must have completed all of the information required in this Part 2 Notice of Claim and it must be declared before a Justice of the Peace or Solicitor.

The form must be signed by the injured person unless he/she is under 18 or is unable to complete it. In these cases it must be completed by a parent, guardian, relative or friend of the injured person.

**You <u>must</u> also give your written permission to allow the respondent or their insurer to obtain any records or information that may affect your claim from:**

- The insurers;
- A department, agency or instrumentality of the Commonwealth, the State or another State administering police, transport, taxation or social welfare laws;
- A hospital;
- The ambulance or other emergency service of the State or another State;
- A doctor or other health-care provider;
- An educational institution;
- An employer (or previous employer).

**Under Section 73 of the *Personal Injuries Proceedings Act 2002* you can be fined up to $11,250 or be imprisoned for up to one (1) year for knowingly providing false, misleading or incomplete particulars in this form. Therefore, all the information you have given in the Notice of Claim must be true, correct and complete.**

## Claimant's Declaration and Authorisation

I hereby authorise the respondent against whom this claim is made or their insurer to contact those persons and entities mentioned within Part 2 of the Notice of Claim and to obtain information and documents relevant to the claim.

I do solemnly and sincerely declare that the statements of fact contained in this Part 2 Notice of Claim (Health Care Claim) (including the attached pages) are true, correct and complete in every respect and I make this declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1867*.

_____

**(Signature)**

TAKEN AND DECLARED BEFORE ME: _____

**(Signature of Justice of the Peace or Solicitor)**

ON: _____ / _____ / _____

AT (*plac*e): _____

Justice of the Peace or Solicitor's Name: _____

Address: _____

Injured Person's Surname/Family Name:_____

Given Names: _____

**IF ANOTHER PERSON SIGNED ON BEHALF OF THE INJURED PERSON:**

Give Details of the Person who Signed the Form:

Person's Surname/Family Name:_____

Given Names: _____

Address: _____

_____

Home Telephone Number: (_____) _____

Relationship to the Injured Person: _____

Reason/s why the injured person could not sign: _____

## INSTRUCTIONS TO CLAIMANT FOR COMPLETING THIS FORM

What you need to do -

- Use this form **if you personally suffered an injury** in a medical incident due to the fault of another person.

OR

- Use this form **on behalf of an injured person** who is unable to personally complete the information. (All of the answers to questions contained in the form must relate to the injured person.)

- To make a claim as a relative/dependant, for loss resulting from a person sustaining a **fatal injury** do not use this form. You must complete the Notice of Claim (Dependency Claims) form.

- **Give initial notice of the claim as soon as possible**. Your claim could be rejected if the respondent receives initial notice under section 9A of the Act past the earlier of the following two dates:

    - the day **nine (9) months** after the day of the incident or the first appearance of symptoms of the injury.

    - the day **one (1) month after you first instructed a law practice** to act on your behalf in seeking damages for the personal injury.

- **Part 1 of your written Notice of Claim must be provided within 12 months of the initial notice procedure.**

- **Part 1 of the Notice of Claim must be provided with a medical report from a specialist medical practitioner who is of the opinion that a breach of accepted medical practice has resulted in the injury alleged.**

- **Keep a copy of the completed form** and any other papers included in your claim so that you have your own record.

- **You can negotiate with the respondent** and settle the claim yourself. It is important for you to know your rights. You could have a dispute with the respondent about the amount payable to you. If you are unsure what to do a solicitor can advise you what needs to be done and how much it will cost.

- **Tear off these three instructions pages and keep them**. They will be useful as a reminder of what you need to do, and also what you can expect to happen with your claim.

# The person at fault

It is essential that you name the person or persons you regard at fault in the incident (see question 13) - that is, the person you believe caused the incident – and the reasons why (see question 14).

**You must provide each person at fault with a Notice of Claim**.

You must place the name and address of the respondent who you are giving the notice to on the cover of the Notice of Claim. If the Respondent is the State of Queensland, you must nominate the government Department you consider responsible.

# STEPS TO COMPLETE THIS FORM AFTER GIVING INITIAL NOTICE

## STEP 1

**Please use a black or blue pen** and print clearly or type your answers into the form. Start from question 1 and work your way through Part 1 of the form carefully, following the 'go to' instructions. Attach a separate page with further information if there is not enough space on the form.

**You must answer questions truthfully** and answers must be complete as far as you know or can reasonably find out.

***Severe penalties apply where false or misleading information is given.***

The statements of fact contained in this notice of claim must be true, correct and complete and be signed in the presence of a Justice of the Peace or a Solicitor.

***Before you sign the form read it carefully*, as the declaration of fact at end of the form is to be made in accordance with the Oaths Act 1867.**

### STEP 2

**Give Part 1 of your notice of claim** to the person whom you believe caused the incident so that is received no later than **nine (9) months** after the date of the incident or first symptoms of injury or within **one (1) month** of instructing a law practice to act on your behalf in seeking damages for the personal injury (whichever is the earlier).

If you believe the State of Queensland caused the incident, then the Notice of Claim must nominate the Department which you believe caused the incident and be delivered to:

Crown Law
Level 11
State Law Building
50 Ann Street
BRISBANE QLD 4000

OR

Crown Law
GPO Box 149
BRISBANE QLD 4001

Facsimile: (07) 3239 0407

**STEP 3**

After forwarding Part 1 of the Notice to the person/s, **start completing Part 2 of the Notice.** Again, **please use a black or blue pen** and print clearly or type your answers. Work your way through Part 2 of the form carefully, following the "go to" instructions. Attach a separate page with further information if there is not enough space on the form.

You must forward Part 2 of the Notice to the person/s you forwarded Part 1 to within two (2) months of the person's first reply to your Part 1. If they do not reply within 1 month, then you must forward Part 2 of the Notice to them within two months of that date (that is, within three months of the day you first gave them Part 1 of the Notice).

# WHAT WILL HAPPEN AFTER YOU SEND YOUR NOTICE OF CLAIM TO THE RESPONDENT

- The **respondent** is the person or persons who you believe is responsible for the incident and who will receive this completed form.

- **You will get a letter from the respondent** telling you that your claim has been received. It will include the name and telephone number of a contact person.

- **You must be prepared to help the respondent with their investigation** of the incident. You may be required to give specific information, photographs, documents or records, and you may have to have a medical examination or assessment. You must also take all reasonable steps to recover from your injury by having all recommended treatment and rehabilitation, and to reduce your lost income – for example seeking alternative work.

- **The obligation of the respondent** in relation to your claims is to:

  - Within one (1) month after receiving Part 1 of your notice of claim, advise you if there are any areas in the form where the information is deficient;

  - Within six (6) months of receiving a complying Part 1 notice of claim, advise you whether liability is admitted or denied and if admitted to what percentage;

  - If liability is admitted, advise you the respondent is prepared to accept your offer of settlement if you have made one or invite you to make an offer as soon as possible.