Service request form
Fit for work service

Claim & referral details

Worker name		Worker date of birth	
Claim number		Date of injury	
Claims agent		Case manager	
Employer			
Weekly income maintenance at referral		Certified work capacity threshold at referral	
Pre-injury work capacity (hours per week)		Current work capacity (hours per week)	

Section 1 (to be completed by provider)

1.1 Request

☐ Training course request (start date) (end date)

- Course title
- Training provider (company name) (phone no)
- Course cost
- Other related costs (details) (cost)
- Related suitable employment goal
- Certification by treating doctor in fitness upgrade program obtained YES / NO

☐ Fitness upgrade service extension: 4 weeks (start date) weeks (max. 4)

☐ Additional travel for regional areas

☐ Service suspension, period of suspension (start date) (end date)

☐ Service closure (proposed closure date)

1.2 Rationale for request

Provide rationale for request (for training requests, specific details regarding the training schedule should be detailed):

1.3 Provider details

Print name:
Position:
Company name:
Address:
Phone number:
Email address:
Signature:
Date:

Section 2 (to be completed by claims agent, and return to the provider by email within two business days)

Fit for work service request approved: ☐ Yes ☐ No ☐ Further evidence required

Comments/Action required:

Case manager name:
Company:
Address:
Phone number:
Email address:
Signature:
Date: