

REQUISITION FOR COMPENSATION

Workers Name: _____

Workers Compensation Claim Number: _____

Pay Period From: ___/___/___ to ___/___/___

Day	Date	Hours Worked	Leave Type	Day	Date	Hours Worked	Leave Type
Monday				Monday			
Tuesday				Tuesday			
Wednesday				Wednesday			
Thursday				Thursday			
Friday				Friday			
Saturday				Saturday			
Sunday				Sunday			
Total				Total			

Note: Hours Worked (is the actual hours worked by the injured worker at the workplace)
 Leave Type (is any sick / annual / other leave unrelated to their claim)

Normal Weekly Hours: (indicate hours worked each day as per employment contract)	Mon	Tue	Wed	Thurs	Fri	Sat	Sun
Current Medical Certificate (please circle)	YES				NO		
Work Cover or Income Protection Claim (please circle)	YES				NO		
Managers Name:							
Managers Signature:							