**Injured/Ill Worker Authorisation Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of Uniting Church in Australia (Qld)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Give consent for my Rehabilitation and Return to Work Coordinator (RRTWC), Christine Przibilla to gather information, either verbal or written, in relation to my injury/illness from my medical and other health professionals. This information will be gathered for the sole purpose of the assessing the impact of my injury/illness on my ability to perform my current role at my workplace.

I understand that this information will be treated in confidence and will be used for the following purposes only:

1. The management of my rehabilitation/suitable duties program;
2. To ensure my safety at work; and
3. To provide any ongoing workplace support services as required.

*Please note: Your personal information will not be disclosed to any person or agency without your express consent. Your personal information may be disclosed to a health care professional in relation to the above purposes only. The personal information collected will not be included in your personnel file.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Signed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_

Witness Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Witness Signature