**AUTHORITY AND CONSENT FORM**

In order to provide a safe workplace, employees must be able to perform the essential duties of their jobs in a safe, secure, productive, and effective manner, without presenting a safety hazard to themselves, other employees, the university, or the public**.**

As you have advised that you currently have a medical condition which impacts your ability to perform the essential duties of your job we are obligated to determine and manage your non work related injury to ensure that we continue to provide a safe workplace.

To achieve this we are required to discuss with your treating medical practitioner some of your personal medical information and require your consent.

Can you please complete and sign the following:

**Claimant Details**

Family Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Given Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authority**

In relation to my non work related injury, I authorise my treating medical practitioner to discuss my injury, any implications my injury may pose on my work obligations and any alternative work options with a representative from Edith Cowan University.

I agree that a physical or electronic copy of this authority shall be considered as effective and valid as the original.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Signature of injured party Date

A copy of the authority has been provided to the treating medical practitioner.

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Edith Cowan University Representative Signature of Representative Date