Office Use Only:

ENTERED: ☐

SCANNED: ☐

ACC 45 FORM

SECTION 4 - ACC45 -		**PHYSIO TO COMPLETE**	
CLIENT NAME:		**ACC45 No:** (For office use)	
Is this an ACC Injury ☐ YES ☐ No			
Date of Injury:	**Time of Injury:** ☐ **am** ☐ **pm**	**READ CODE/S:** 1 2 3	**SIDE:** ☐ LEFT ☐ RIGHT ☐ LEFT ☐ RIGHT ☐ LEFT ☐ RIGHT
Location: (e.g Christchurch, Auckland)	**Place of Injury**: (e.g. Home, School, Road)	**Additional Injury Comments to injury code**	

How did the injury happen? (Describe)

Ethnicity:	☐ NZ European/Pakeha ☐ Cook Island Maori ☐ Fijian ☐ Indian ☐ Samoan ☐ Other European ☐ Tongan ☐ Other Pacific ☐ Other Asian ☐ Tokelauan ☐ NZ Maori ☐ Niuean ☐ South East Asian ☐ Chinese ☐ Other ☐ I'd prefer not to say
Occupation:	

Please tick those that apply: ☐ I am in paid employment ☐ I own/part-own the company in which I work ☐ I am self-employed ☐ I am not in paid employment

Work Intensity: ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy

Did the accident occur at work? ☐ YES ☐ NO

What is the name of the business you are employed by/own?	
What is the address of the business you are employed by/ own?	

Is this injury as a result of a motor vehicle accident? ☐ YES ☐ No

Is this injury a result of a sport accident? ☐ YES ☐ No	**Type of sport:**

ACC DECLARATION:

I DECLARE – The information I have given about this claim is true and correct and that I have not withheld any information.
I AUTHORISE – The treatment provider to lodge the claim for me. The collection and release of any information about me to the extent that this is needed to prevent future injuries, determine cover and/or assess my entitlement to compensation, rehabilitation assistance, medical treatment and/or the appropriate level of care and personal attention I should receive. ACC to contact anyone who holds relevant information, including any external agencies or service providers (such as medical practitioners, specialists, New Zealand Police and Treatment Providers, IRD, WINZ, Assessment Agencies, employers and witnesses to the accident.

SIGNED: (*If under 16 must be signed by parent/guardian)* **DATED:**

PHYSIOTHERAPIST SIGNED: **DATED:**