



1: LOSS OF INCOME CLAIM FORM

Players Full Name:
Address:
.....Postcode
Phone Number (H)(w) Date of Birth / /
Employed by:
Address;
Club:Grade; 1st 2nd 3rd 4th
Nature of Injury: Date of Injury: / /
Certificate from Doctor:attached
Dependants: Spouse: Children: Number of Children:
I declare the amount of income loss by me during the above period amounted to \$.....
Calculated as follows:
..... weeksdays lost from work at normal wage of \$.....per week
Signature of Player: Date: / /

2: CERTIFICATE BY CLUB SECRETARY

I certify that playersustained a
.....while playing at
..... on / / . during practice / match
Authorised by this Club.
.....
Name of Club Secretary or claims Officer Signature
Contact Phone Number:

3: CERTIFICATE BY EMPLOYEE / SELF EMPLOYEE

It is certified that:(Employee) / (Self Employed)
is employed by:(Employer)/ (Business Name)
of (Employed Address)
Phone Number:
He was absent from work WITHOUT PAY for the period: toincl.
His loss of wages during this period wasdays amounting to \$.....at his normal wage
of \$ per week.
.....
Contact Name Signature and Position