SCOTTISH AMBULANCE SERVICE
APPLICATION FOR INJURY ALLOWANCE

This form should only be completed for an injury or disease occurring on or after 31 March 2013

Please note that injury allowance will not be payable if the accident or illness was wholly or mainly due to, or seriously aggravated by, your own culpable negligence or misconduct.
Please complete Part 1 and forward to the Human Resources Department who will complete Part 2 and submit to the Director of Human Resources.

PART 1 – TO BE COMPLETED BY THE APPLICANT

SECTION 1 – PERSONAL DETAILS (to be completed in all cases)

Payroll Number	Group Code	Pay Point

Surname:									
Forenames (in full):									
Title:									
Dr		Mr		Mrs		Miss		Ms	
Other title (please specify):									
National Insurance number:									
Date the injury occurred? (after 31/03/2013)									

Contact Address:									
Postcode:									
Date of birth (e.g. 18/07/1964):									
		/			/				
Telephone/mobile number:									
Email address:									
		/			/				

Current Post	
Job Title	

Location	
Dept / Site	

Post at time of Injury	Location
Job Title	Dept / Site

SECTION 2 – FURTHER INFORMATION

1. Please give details of all your previous employment showing where you have worked, with dates if possible

2. Please give a description of the incidents(s) leading to your injury or illness and the type of injury or illness suffered (continue on a separate sheet if necessary).

3. Have you applied or are you in receipt of any DWP benefits as a result of your injury?

Yes ☐ No ☐

If the answer is “no” to question 3 but you later claim DWP benefits you must notify the Scottish Ambulance Service Payroll Department immediately.
Please read and sign the declaration on page 3, enclosing copies of any DWP awarding letters you have received, where possible.
I have included the following documents with my application (please specify below, indicating if you have sent these to us separately). Do not send us originals unless you have to, copies are preferred. Please ensure all documents are marked with your Payroll Number.

SECTION 3 – DECLARATION (please read before signing)
(Without a signed declaration we cannot accept your application)

- I hereby apply for NHS Injury Allowance due to injury/disease which I consider to be wholly or mainly attributable to the duties of my employment with the Scottish Ambulance Service.
- I understand that certain DWP benefits paid in relation to my injury are taken into account with NHS injury allowance.
- I will notify the Scottish Ambulance Service if I have claimed or intend to claim any DWP benefits or if my DWP benefits change in amount or cease to be paid.
- I understand responsibility lies with me to keep the Scottish Ambulance Service informed of any changes in DWP benefits.
- I agree to provide the Scottish Ambulance Service with copies of any awarding documents for DWP benefits and any subsequent changes to benefit awards.
- I authorise the Scottish Ambulance Service to obtain medical evidence connected to my Injury Benefit Claim and/or monetary details of my DWP details, and any subsequent changes from the DWP.
- I agree that any medical information required to make a decision on my case, will be obtained by me at my expense from my GP/Consultant, and/or other sources.
- I give consent for the Scottish Ambulance Service to approach my Occupational Health Department or any other relevant sources for information if required.
- I am willing to undergo a medical examination if asked to do so.
- I understand that any payment of Injury Allowance is subject to tax and national insurance deductions and that my payments will be processed by the Scottish Ambulance Service Payroll Department.
- I understand that any overpayment on my Injury Allowance will be recovered and must be repaid by me.
- I will notify the Scottish Ambulance Service Payroll Department if/when I return to any NHS post or if my NHS employment is terminated.
- I declare the details I have given in Part 1 of this form are correct to the best of my knowledge.

Signature	
Print Name	
Date:	/ /

PART 2– TO BE COMPLETED BY HUMAN RESOURCES DEPARTMENT

In order to avoid delay in processing, the following information should, where possible accompany this application form. Tick the boxes to indicate which papers are being enclosed.

☐ Incident Report Form

☐ Occupational Health Records

☐ Job Description

☐ Other papers included. Please specify below (for example – witness statements)

PART 3– TO BE COMPLETED BY PANEL

1.

Panel Membership Name	Job Title

2.

Approved / Not Approved *
Reason for non approval

Signature										
Name (Print)										
Date:			/			/				

* Delete as appropriate