The purpose of this form is to verify the information provided in the annual End of Year Reconciliation as required by the Determination in accordance with section 114 of the Workers Rehabilitation and Compensation Act 1988. This form is to be submitted to the WorkCover Information Management System (WIMS) by the close of business on the 31 August each year.

This form must be completed and signed by both the person providing the verification and an authorised person of the insurer.

The certifying person should be suitably qualified to undertake such an evaluation and can be internally independent or an independent external person.

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

***Certifier to Complete***

*(All fields must be completed)*

I have reviewed the information supplied to the WorkCover Tasmania Board as part of the End of Year Reconciliation data submission. I **attach** a copy of the information submitted to WIMS.

In my opinion, the information provided by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for the period \_\_/\_\_/\_\_\_\_ to \_\_/\_\_/\_\_\_\_ presents fairly, in all material respects, in accordance with generally accepted Australian accounting standards to the extent applicable to the End of Year Reconciliation submitted as required by the Determination and section 114 of the *Workers Rehabilitation & Compensation Act 1988.*

Name of Certifier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Qualification:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organisation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

……………………………………………………..

Signature of Certifier

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

***Authorised Officer to complete***

*(All fields must be completed)*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the undersigned do hereby state that I have the authority to act on behalf of XXXXXXXX. I endorse the information submitted in the End of Reconciliation Certificate and the verification of that information as above.

…………………………………………………….

Signature of Licenced or Self-Insurer

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

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*This certificate is to be submitted to the WorkCover Information Management System (WIMS) no later than close of business each year on 31 August.*