

13.1 SECTION 38 (provides among others)

NOTICE OF ACCIDENT BY EMPLOYEE TO EMPLOYER (paragraphs 1 and 2)

Written or verbal notice of an accident shall, as soon as possible after such an accident happened, be given by or on behalf of the employee concerned to the employer, and notice of the accident may also be given as soon as possible to the Commissioner in the prescribed manner.

Failure to give notice to an employer as required in subsection (1) shall not bar a right to compensation if it is proved that the employer had knowledge of the accident from any other source at or about the same time of the accident.

13.2 SECTION 22 (provides among others)

RIGHT OF EMPLOYEE TO COMPENSATION (paragraphs (1) and (3)(a))

If an employee meets with an accident resulting in his disablement or death, such employee or the dependants of such employee shall, subject to the provisions of this Act, be entitled to the benefits provided for and prescribed in this Act.

If an accident is attributable to the serious and wilful misconduct of the employee, no compensation shall be payable in terms of this Act, unless the accident results in serious disablement or death.

13.3 SECTION 90 (provides among others)

REVIEW OF DECISIONS BY DIRECTOR GENERAL (paragraph (1)(d))

The Commissioner may, after announcing his decision review it on the grounds that -

the decision or award was based on an incorrect view or misrepresentation of the facts, or that the decision or award would have been otherwise in the light of evidence available at present but which was not available when the Commissioner made the decision or award.



FREE STATE PROVINCIAL GOVERNMENT

Health

Name:, Institution:

Director: Human Resources
Occupational Injuries and Diseases Section
P.O. Box 227
BLOEMFONTEIN 9300

Ref.:

**COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT,
1993 (ACT NO. 130 OF 1993)**

EMPLOYEE:
DATE OF INJURY/DISEASE:
YOUR REFERENCE:

1. The following duplicate documents in connection with the above-mentioned injury/disease are attached:

- (a) W.CL.2/W.CL.1 Employer's Report
- (b) W.CL.3/W.CL.14 Claim for Compensation
- (c) W.CL.4/W.CL.22 First Medical Report
- (d) W.CL.5/W.CL.26 (Progress) Medical Report
- (e) W.CL.5/W.CL.26 (Final) Medical Report
- (f) W.CL.6 Resumption Report
- (g) Radiology Report
- (h) Clinical description
- (i) Statement of employee/witness/supervisor
- (j) Others
- (k) Z1 Leave form
- (l) Choice of doctor

2. **REMARKS:**

.....
.....

HEAD: HEALTH

Date:

ANNEXURE 2

CHOICE OF DOCTOR: INJURY ON DUTY BY EMPLOYEES OF THE DEPARTMENT OF HEALTH IN THE FREE STATE

An employee is permitted to choose freely his own doctor, and no interference with this privilege is permitted as long as it is exercised reasonably and without prejudice to the employee himself or the Compensation Fund. As an employee of the Department of Health, are you aware that you are entitled to **free medical treatment** if treated by full-time/part-time medical staff of a District or Regional Hospital? (As set out in the Provincial Gazette Free State Province, No. 25 of Friday, 14 April 2000, Provincial Notice No. 50, regulation 8(1)(g)(ii).)

I the undersigned (full names) _____
prefer to be treated by

- (a) Full-time Medical Officer _____
(That is employed by a District or Regional Hospital)
- (b) Part-time Medical Officer _____
(Medical Officer in the private sector who does sessions at the hospital and is therefor remunerated by the Department)
- (c) My Private Doctor _____

Signed at _____ on this day of _____
_____ at _____ (time) for
a consultation at the hospital/doctor's consulting room _____

NB. The employee must also append his signature against the choice he has made and this form must be submitted to the particular doctor by the employee together with page 1 (part B) of the W.C.L.2 (during the first consultation if possible).

DECLARATION BY EMPLOYER

1. In what capacity did the doctor treat this employee: As a Full-time/Part-time or Private Doctor, as a Specialist/General Practitioner.
2. The employee's admission category, if he received treatment at a District/Regional Hospital is **H4 Hospital Patient/Private Patient.**

IMPORTANT

.....
Signature of employer or his authorised representative

.....
Signature of doctor who treated patient



FREE STATE PROVINCIAL GOVERNMENT

Health

....., Human Resources Directorate, Personnel Maintenance Subdirector, Occupational Injuries and Diseases Section, P.O. Box 227, Bloemfontein 9300, Tel. No. (051) 403....., Fax no. (051) 4033129

Ref.:

.....
.....
.....
.....

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 (ACT NO. 130 OF 1993)

**REOPENING
EMPLOYEE:**

DATE OF INJURY:

1. With reference to your report/letter/telephonic enquiry/ies dated this office must inform you that the employee's case was concluded on

2. If you are of the opinion that the employee's condition has deteriorated in such a way that the case must be re-opened the employee must submit the following documents at his own expense to this office for consideration.

(a) A complete medical report which describes his present clinical condition and continuing anatomical defects and/or limitation of function(s) resulting from the accident.

(b) A description by the doctor of the connection between the present condition and the original injury/ies on

(c) A description of the nature of the intended medical treatment.

(d) Where applicable the application must also be supported by additional reports of recent radiological and/or any other diagnostic examinations which can be of assistance in determining the re-opening of the case.

3. If after consideration of the medical evidence approval for the re-opening of the case is granted, payment at prescribed tariffs of the expenses incurred by the employee will be considered by the Compensation Commissioner.

HEAD: HEALTH

Date:



FREE STATE PROVINCIAL GOVERNMENT

Health

Mrs E.J. Rehbock, Human Resource Management Directorate, Conditions of Service Subdirector, Occupational Injuries and Diseases Section, P.O. Box 227, Bloemfontein, 9300, Tel. (051) 4098334, Fax (051) 4098324

TO ALL HEADS OF OFFICES AND INSTITUTIONS
OF THE DEPARTMENT OF HEALTH
IN THE FREE STATE

HEALTH HUMAN RESOURCE MANAGEMENT CIRCULAR NO. ...69.... OF
2002

INFORMATION AND PROCEDURES THAT SHOULD BE FOLLOWED WITH REGARD TO THE REPORTING OF A NEW OCCUPATIONAL INJURY OR -DISEASE

1. All injuries/diseases or alleged injuries/diseases which result in expenditure on medical treatment or absence from work or permanent incapacity to work or death must be reported in the prescribed manner.
2. Section 39 of the Compensation for Occupational Injuries and Diseases Act of 1993 (Act No. 130 of 1993) stipulates, among others:

(Notice of Accident by Employer to Commissioner (paragraphs (1) and (7))

Subject to the provisions of this Section an employer shall within 7 days after having received notice of an accident or having learned in some other way that an employee has met with an accident, report the accident to the Compensation Commissioner in the prescribed manner.

For the purpose of this Section an accident includes any injury reported by an employee to his employer, if the employee when reporting the injury alleges that it arose out of and in the course of his employment and irrespective of the fact that in the opinion of the employer the alleged accident did not arise out of



and in the course thereof.

- 2 -

3. **Section 68 of the Compensation for Occupational Injuries and Diseases Act of 1993 (Act No. 130 of 1993) stipulates, among others:**

Notice of Occupational Disease by Employee and Employer)

That an employer shall within 14 days after having so received notice that an employee has contracted a disease referred to in Section 65 report such disease in the prescribed manner to the Compensation Commissioner, irrespective of whether he/she may be of the opinion that the employee did not contract such disease in his employ.

4. In order for the Occupational Injuries and -Diseases Section to comply with the instructions as prescribed in Section 39 and 68 of the Act it is imperative for reports to be submitted immediately to this Section as to ensure that it will reach the Compensation Commissioner within either 7 or 14 days as the case may be.
5. According to Section 40 of the Act an employer who fails to submit further details of an accident/injury or such further facts of which he/she has knowledge, which the Commissioner may require to enable him to decide upon any claim or liability in terms of this Act, is guilty of an offence and may the Compensation Commissioner refuse to adjudicate on the claim of an employee who fails to furnish such further particulars as the Compensation Commissioner may require.
6. The penalties for a late claim may be as high as the total claim cost, which includes all monetary awards and the cost of medical aid.
7. In a letter from the Compensation Commissioner it is stipulated: "In conclusion I must draw your attention to the fact that unless the reporting time for occupational injuries/diseases are not brought in line with the prescriptions of the Act, I have no option but to impose penalties as outlined above".
8. It is the responsibility of all supervisors of injured employees to complete the W.C.L. 2 and to get hold of all outstanding documents in connection with the injury/disease and to send it immediately to the Personnel Section who will immediately send it to Section Occupational Injuries and -Diseases. It must be in such a time that the above-mentioned section will be able to report the injury within 7

days to the Compensation Commissioner and a disease within 14 days.

- 3 -

9. It is not permissible for any supervisor or any official from the Personnel Section of an institution to send any documents directly to the Compensation Commissioner. It must be reported to the Section Occupational Injuries and -Diseases (at Head Office), P.O. Box 227, Bloemfontein 9300.
10. The Chief Executive Officer of an institution will be notified if the procedures are not correctly and in time followed.

*Signed by: Me. M. Mabitle
HEAD: HEALTH

Date: 29 / 08 / 2002



FREE STATE PROVINCIAL GOVERNMENT

Health

Mrs D. Magson, Human Resources, Personnel Maintenance, P.O. Box 227, Bloemfontein 9300, Tel. (051) 4033032,
Fax (051) 4033577, Email: MAGSOND@DOH.OFS.GOV.ZA. Room 609, Trustfontein Building, St Andrew Street, Bfn.

TO ALL HEADS OF OFFICES AND
INSTITUTIONS OF THE DEPARTMENT
OF HEALTH IN THE FREE STATE

HEALTH HUMAN RESOURCE CIRCULAR NO. ...26.... OF 2001

**GENERAL INFORMATION AS WELL AS PROCEDURES THAT SHOULD BE
FOLLOWED WITH REGARD TO NEEDLE PRICKS**

The above-mentioned circular is attached for your information. Kindly bring its contents to the attention of all staff concerned.

HEAD: HEALTH Mr. C. Gardner (Director H-R)

Date: 6 / 4 / 2001

GENERAL INFORMATION AS WELL AS PROCEDURES THAT SHOULD BE FOLLOWED WITH REGARD TO NEEDLE PRICKS (Read with Health Circular No. of 1999: Implementation of policy on occupational exposure to HIV and post exposure prophylaxis)

1. **Needle pricks**
 - 1.1 All needle pricks must be reported immediately in the prescribed manner (See paragraph 2.1.)
 - 1.2 The HIV status of the employee as well as that of the contact person should be ascertained immediately or within 24 hours after exposure. The employee should be re-tested as is necessary after that to confirm seroconversion within a reasonable, probable period.
 - 1.3 Approval has been given to District and Regional Hospitals to bear the cost of laboratory tests if they are done by the laboratory of the hospital or a laboratory which has a contract with the hospital. The above said circular should be consulted with regard to treatment.
 - 1.4 Expenses incurred by employees with a private doctor, hospital or laboratory will therefore not be borne by this Department.
 - 1.5 **No prophylactic treatment is ever payable by the Compensation Commissioner or Department of Health.** If seroconversion occurs the claim should be lodged with all applicable documentation to support the employee's claim. When the claim has been accepted, costs for tests, etc. will be reimbursed and reasonable costs in respect of treatment will be paid. Please take note that the Compensation Commissioner only decides whether the cost of any treatment is reasonable in terms of the Compensation for Occupational Injuries and Diseases Act, 1993 and will therefore instruct this Department to accept liability for the payment thereof.
 - 1.6 If and when an employee becomes permanently unable to do any work, a percentage of permanent disablement will be determined by the Compensation Commissioner, which could be a monthly pension payable up to death.

1.7 **Section 68 of the Compensation for Occupational Injuries and Diseases Act of 1993 (Act 130 of 1993) stipulates, among others:**

That an employer shall within 14 days after having so received notice or having learned in some other way that an employee has contracted a disease referred to in Section 65(1), report such disease in the prescribed manner to the Commissioner or mutual association concerned, as the case may be, irrespective of whether he may be of the opinion that the employee did not contract such disease in his employ. An employer who fails to comply with these instructions shall be guilty of an offence.

In order for the Occupational Injuries and Diseases Section to comply with the instructions as prescribed in Section 68 of the Act, it is imperative for reports to be submitted immediately to this Section as to ensure that it will reach the Compensation Commissioner within 14 days.

1.8 **Section 65 of the Compensation for Occupational Injuries and Diseases Act of 1993 (Act 130 of 1993) stipulates, among others:**

- (1) That subject to provisions of this Chapter, an employee shall be entitled to the compensation provided for and prescribed in this Act if it is proved to the satisfaction of the Director-General that the employee has contracted a disease that has arisen out of and in the course of his or her employment.
- (4) Subject to Section 66, a right to benefits in terms of this Chapter shall lapse if any disease is not brought to the attention of the Commissioner or the employer or mutual association concerned, as the case may be, within 12 months from the commencement of that disease.
- (5) For the purposes of this Act the commencement of a disease referred to in this section shall be deemed to be the date on which a medical practitioner diagnosed that disease for the first time or such earlier date as the Director-General may determine if it is more favourable to the employer.

~~2. PROCEDURE WHEN REPORTING A NEEDLE PRICK~~

- 2.1 In all circumstances use the prescribed covering letter (Annexure 1) when dispatching documents.

- 2.2 All documents must be submitted in duplicate – the original and one copy.
- 2.3 The employer must complete form W.C.L.1 Employer's Report Of An Occupational Disease, in detail.

On page two of the form W.C.L.1, the registered name must be furnished to the Compensation Commissioner as follows: FS Provincial Administration Department of Health, P.O. Box 227, Bloemfontein 9300 and the registration number allocated by the Compensation Commissioner, 1183/659/006x.

With regard to diseases the form W.C.L.1 must be completed and signed immediately and a copy sent with the employee to the doctor or hospital without delay, so that the doctor may fill in the form, First Medical Report in respect of Disease (W.C.L.22) and sent it to the employer.

The advantage of the above procedure is that the hospital or doctor is not dependent on the information obtained from the injured employee, but gets the basic details required from the employer himself. This will eliminate wrong spellings of names which may cause confusion in the Office of the Compensation Commissioner or that accounts are sent to the wrong address.

The person who signs the "DECLARATION BY EMPLOYER OR AUTHORISED PERSON" which is at the top of page 2 of the W.C.L.1 must indicate his/her name in print. Take note that the responsibility for the completion of the W.C.L. form is that of the supervisor and not of the employee.

- 2.4 Form W.C.L.1 together with the form, Claim for Compensation (W.C.L.14) and the First Medical Report (form W.C.L.22) **must be submitted without delay and not held back until the employee's condition has stabilised** and he/she has resumed duty. In cases of long absence a Progress Medical Report (W.C.L.2) must be obtained and submitted monthly. As soon as the employee has resumed duty, a Resumption Report (form W.C.L.6), and sick leave application must be completed and submitted together with a **Final Medical Report** (form W.C.L.26) or a further Progress Medical Report. In cases of absence of long duration the leave form and the Resumption Report must be submitted monthly until the employee resumes duty.

2.5 The employee has a free choice of doctor and only the form pertaining to the choice of doctor furnished by the Occupational Injuries and Diseases Section (Annexure 2) shall be accepted.

2.6 **Section 40 of the Compensation for Occupational Injuries and Diseases Act of 1993 (Act 130 of 1993) stipulates, among others:**

that an employer who fails to submit such further details of an accident/ injury or such further facts of which he/she has knowledge, which the Commissioner may require to enable him to decide upon any claim or liability in terms of this Act, is guilty of an offence and may the Compensation Commissioner refuse to adjudicate on the claim of an employee who fails to furnish such further particulars as the Commissioner may require.

2.7 The forms that must be completed in respect of occupational injuries/ diseases are not provided by this Directorate and it is the responsibility of each institution to either telephonically (012-3199111 – store division) or in writing request them directly from the Compensation Commissioner. (Relevant forms: W.C.L. 1, 6, 14, 32, 69 and the Travelling Questionnaire – all other W.C.L. forms will be provided either by the doctor or the Compensation Commissioner.)



FREE STATE PROVINCIAL GOVERNMENT

Health

Name:, Institution:

Director: Human Resources
Occupational Injuries and Diseases Section
P.O. Box 227
BLOEMFONTEIN 9300

Ref.:

**COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT,
1993 (ACT NO. 130 OF 1993)**

EMPLOYEE:

DATE OF INJURY/DISEASE:

YOUR REFERENCE:

1. The following duplicate documents in connection with the above-mentioned injury/disease are attached:

- (a) W.CL.2/W.CL.1 Employer's Report
- (b) W.CL.3/W.CL.14 Claim for Compensation
- (c) W.CL.4/W.CL.22 First Medical Report
- (d) W.CL.5/W.CL.26 (Progress) Medical Report
- (e) W.CL.5/W.CL.26 (Final) Medical Report
- (f) W.CL.6 Resumption Report
- (g) Radiology Report
- (h) Clinical description
- (i) Statement of employee/witness/supervisor
- (j) Others
- (k) Z1 Leave form
- (l) Choice of doctor

2. **REMARKS:**

.....
.....

HEAD: HEALTH

Date:

CHOICE OF DOCTOR: INJURY ON DUTY BY EMPLOYEES OF THE DEPARTMENT OF HEALTH IN THE FREE STATE

An employee is permitted to choose freely his own doctor, and no interference with this privilege is permitted as long as it is exercised reasonably and without prejudice to the employee himself or the Compensation Fund. As an employee of the Department of Health, are you aware that you are entitled to **free medical treatment** if treated by full-time/part-time medical staff of a District or Regional Hospital? (As set out in the Provincial Gazette Free State Province, No. 25 of Friday, 14 April 2000, Provincial Notice No. 50, regulation 8(1)(g)(ii).)

I the undersigned (full names) _____
prefer to be treated by

- (a) Full-time Medical Officer _____
(That is employed by a District or Regional Hospital)
- (b) Part-time Medical Officer _____
(Medical Officer in the private sector who does sessions at the hospital and is therefor remunerated by the Department)
- (c) My Private Doctor _____

Signed at _____ on this day of _____
_____ at _____ (time) for
a consultation at the hospital/doctor's consulting room _____

NB. The employee must also append his signature against the choice he has made and this form must be submitted to the particular doctor by the employee together with page 1 (part B) of the W.C.L.2 (during the first consultation if possible).

DECLARATION BY EMPLOYER

- In what capacity did the doctor treat this employee: As a **Full-time/Part-time or Private Doctor**, as a **Specialist/General Practitioner**.
- The employee's admission category, if he received treatment at a _____ District/Regional Hospital is **H4 Hospital Patient/Private Patient**.

IMPORTANT

.....
Signature of employer or his authorised representative

.....
Signature of doctor who treated patient

Needle Pricks\cir\30.01.2001cb\7

EMPLOYER'S REPORT OF AN ACCIDENT
COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993
 Section 39 – Annexure 13

W.CL 2(E)

(For official use only)

Claim no:

DIRECTIONS FOR COMPLETING OF FORM BY EMPLOYER

This form must be completed:

- 1) Whenever an employee meets with an accident arising out of and in the course of his employment resulting in a personal injury for which medical treatment is required.
- 2) Whenever an employee reports any personal injury to his employer, if in making the report the employee alleges that such injury arose out of and in the course of his employment.

(Where the accidents have caused death, unconsciousness or amputation or where the injured employee is presumed unable to work for a period of at least 14 days, the Regional Director of Labour must ALSO be notified by telephone or fax, without delay).

Step 1 Complete "Part A", page 1 of the form by giving full details, sign and date form where indicated.

Step 2 Detach "Part B" (an automatic copy of "Part A", page 1) by tearing it at the perforation, hand "Part B" to the employee and request him to hand it to the medical practitioner/chiropractor or the hospital concerned. In serious cases "Part B" must be forwarded to the medical practitioner/chiropractor or hospital without delay.

Step 3 Complete "Part A", page 2 of the form giving full details.

Step 4 Forward the completed report of an accident together with the First Medical Report (W.CL.4) (if available) to:

THE COMPENSATION COMMISSIONER
 P.O. BOX 955
 PRETORIA
 0001

TELEPHONE: (012) 319-9111
 FAX (012) 323-8627
 (012) 325-6686
 (012) 326-7889

NB:

- 1) Complete a separate form in respect of each injured employee.
- 2) This form must not be delayed in expectation of the employee resuming employment or awaiting medical reports.
- 3) An employer who fails to report any accident within 7 days to the Compensation Commissioner on this form, shall be guilty of an offence in terms of the Compensation for Occupational Injuries and Diseases Act, 1993 and may be held liable for the full amount of compensation payable in respect of such accident.
- 4) An employer who fails to report accidents that have caused death, unconsciousness or amputation or cases where the injured employee is presumed unable to work for a period of at least fourteen days to the Regional Director of Labour by telephone or fax, shall be guilty of an offence in terms of the Occupational Health and Safety Act, 1993.
- 5) Use the appropriate form for the reporting of occupational diseases. (W.CL.1).
 If an injured employee should leave your employ, please keep record of the address where he can be reached so that monies which might be payable to him from the Compensation Fund, can be sent to him with your assistance.

FOR OFFICIAL USE ONLY

| | |
|-----------|---------------------|
| ACCEPT | CONTROL |
| REPUDIATE | Employer Index |
| | |
| | |
| NAME | |
| | |
| DATE | Claims Registration |

FURTHER PARTICULARS OF EMPLOYEE

39. Earnings of employee at the time of accident:

| | R/Week | R/Month |
|--|--------|---------|
| Gross cash earnings: (Including average payments for overtime and/or commission of a constant character) | | |
| Allowances of a recurrent nature: | | |
| a) Bonuses (i.e. 13th cheque) | | |
| b) Other allowances (specify nature) | | |
| Cash value of: | | |
| Free food | | |
| Free quarters | | |
| Other payment in kind (specify nature) | | |

40. Will the employee during temporary total disablement continue to receive from you:

Free food?

| | |
|-----|----|
| Yes | No |
|-----|----|

Free quarters?

| | |
|-----|----|
| Yes | No |
|-----|----|

41. Are you prepared to make cash payments during temporary total disablement that lasts longer than three months?

| | |
|-----|----|
| Yes | No |
|-----|----|

42. If you have already paid cash to the employee, state the total amount R

43. For what period were such payments made? From/...../..... To/...../.....

44. Number of days per week worked by the employee

45. Date on which the employee ceased work/...../.....

46. Time:

47. Did the employee complete his shift on the day that he ceased work?

| | |
|-----|----|
| Yes | No |
|-----|----|

48. Date on which the employee resumed work/...../.....

49. Time:

(If the employee has not yet resumed work, a Resumption Report (W.CL.6) must be submitted as soon as he does).

50. If the employee was killed in the accident, state name and address of dependant of the employee.

FURTHER PARTICULARS

51. Should the employee have any physical defect, have suffered from any serious disease prior to the accident or has previously received compensation for permanent disablement, give full particulars.

52. Was first aid given in this case?

| | |
|-----|----|
| Yes | No |
|-----|----|

53. If a medical practitioner/chiropractor treated the employee, state his name.

54. If the employee received treatment at a hospital, state name of hospital.

55. Was the accident caused by the employee's: a) Deliberate non-compliance with directions?

| | |
|-----|----|
| Yes | No |
|-----|----|

b) Reckless disregard of the terms of any law or statutory regulation designed to ensure the safety or health of employees or the prevention of accidents?

| | |
|-----|----|
| Yes | No |
|-----|----|

c) Action while under the influence of liquor or drugs?

| | |
|-----|----|
| Yes | No |
|-----|----|

(N.B. If any reply is in the affirmative, the employee must furnish an explanatory statement which must then be attached hereto together with your comments thereon).

56. Name and address of anybody: a) Who witnessed the accident

b) Who was aware of the accident at the time

57. How many other employees were injured in the same accident?

58. If the accident was investigated by the SA Police, state name of Police Station.

59. If motor vehicles were involved, furnish registration number/s.

ANY ADDITIONAL DETAILS CAN BE SUPPLIED ON PART A PAGE 3

EMPLOYER'S REPORT OF AN ACCIDENT

W.C.L 2(E)
PART A PAGE 1

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993
Section 39 - Annexure 13

(For official use only)

Instructions:

Complete the form in block letters and mark appropriate areas (X).

Claim no: _____

DECLARATION BY EMPLOYER OR AUTHORISED PERSON

I hereby declare that the particulars, shown in Items 1 to 59 of this report, of an alleged injury on duty, are to the best of my knowledge and belief true and accurate.

Signed on this _____ day of _____ 19 _____

Signature

EMPLOYER

- Registered name with the Compensation Commissioner
- Registration number of this business with the Compensation Commissioner
- Contact person
- Street address
- Postal code
- Postal address
- Postal code
- Tel. no. (.....)
- Fax no. (.....)
- Situation of business/farm:
- Nature of business, trade or industry

EMPLOYEE

- Is the injured employee a working director working member of a CC owner of partner in the business?
- Surname
- First names
- Id-No.
- Date of birth: / /
- Sex: Male Female
- Marital state: Married Single
- Citizen of
- Personnel no.
- Occupation
- Street address
- Postal code:
- Period in your employ (years/months): / /
- Expected period of disablement (days): 0-13 days 14 & more

ACCIDENT

- Date of accident: / /
- Time
- Place of accident
- District
- Date employee reported accident: / /
- Time

- What task was the employee performing at the time of the accident?
- Period of experience in the task performed (years/months): / /
- Was his action at the time of the accident in connection with your trade or business? Yes No
(If "no" state reasons on reverse side Part A Page 3)

35. Short description of how the accident occurred. (ALSO mark the applicable items on the reverse side of Part A Page 3 and use same for a full description)

(Refer to the machine/process involved, whether the injured person fell or was struck and all the factors contributing to the accident)

- Was the accident a traffic accident on a public road? Yes No
- Nature of injury sustained. (e.g. Index finger of right hand crushed)
Mark any of the following when applicable: Killed Amputation Unconsciousness
- Are you satisfied that the employee was injured in the manner alleged by him? Yes No If not, give reasons.

PART A PAGE 2 MUST ALSO BE COMPLETED, PLEASE.

EMPLOYER'S REPORT OF AN ACCIDENT

W.C.L. 2(E)
PART B PAGE 1

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

Section 39 - Annexure 13

Instructions:

Complete the form in block letters and mark appropriate areas (X)

(For official use only)

Claim no:

DECLARATION BY EMPLOYER OR AUTHORISED PERSON

I hereby declare that the particulars, shown in Items 1 to 59 of this report, of an alleged injury on duty, are to the best of my knowledge and belief true and accurate.

Signed on this day of 19.....

Signature

EMPLOYER

1. Registered name with the Compensation Commissioner
2. Registration number of this business with the Compensation Commissioner
3. Contact person
4. Street address
5. Postal code
6. Postal address
7. Postal code
8. Tel. no. (.....)
9. Fax no. (.....)
10. Situation of business/farm:
11. Nature of business, trade or industry

EMPLOYEE

12. Is the injured employee a working director working member of a CC owner of partner in the business?
13. Surname
14. First names
15. Id-No.
16. Date of birth/...../.....
17. Sex: Male Female
18. Marital state Married Single
19. Citizen of
20. Personnel no.
21. Occupation
22. Street address
23. Postal code:
24. Period in your employ (years/months)/.....
25. Expected period of disablement (days) 0-13 days 14 & more

ACCIDENT

26. Date of accident/...../.....
27. Time
28. Place of accident
29. District
30. Date employee reported accident/...../.....
31. Time
32. What task was the employee performing at the time of the accident?
33. Period of experience in the task performed (years/months)/.....
34. Was his action at the time of the accident in connection with your trade or business? Yes No
(If "no" state reasons on reverse side Part A Page 3)
35. Short description of how the accident occurred. (ALSO mark the applicable items on the reverse side of Part A Page 3 and use same for a full description).
.....
.....
(Refer to the machine/process involved, whether the injured person fell or was struck and all the factors contributing to the accident)
36. Was the accident a traffic accident on a public road? Yes No
37. Nature of injury sustained. (e.g. Index finger of right hand crushed)
- Mark any of the following when applicable: Killed Amputation Unconsciousness
38. Are you satisfied that the employee was injured in the manner alleged by him? Yes No If not, give reasons.
.....

Instructions for medical practitioner/chiropractor or hospital on reverse side.