EMPLOYER'S REPORT OF AN ACCIDENT

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993
Section 6(A) (b) - Annexure 13

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

DECLARATION BY EMPLOYER OR AUTHORISED PERSON

I hereby declare that the particulars, shown in items 1 to 62 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 .....year..... → **Signature**.....

EMPLOYER

1. Registered name with the Compensation Commissioner .....
2. Registered number of this business with the Compensation Commissioner
3. Contact person .....
4. Street address ..... 5. Postal code .....
6. Postal address ..... Postal code .....Tel no .....
9.1 Fax no ..... 10. Situation of business/farm .....
9.2 Email address .....
11. Nature of business, trade or industry .....

EMPLOYEE (COPY OF IDENTITY DOCUMENT TO BE ATTACHED)

12. Is the injured person a | working director | working member of a CC | owner of | partner in the business? | **Not applicable** |
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. Postal address ..... 25. Postal code .....
26. Cell no (..... . ...) .....E-mail: .....
27. Period in your employ (years/months) ..../..... 28. Expected period of disablement (days) | 0-13 days | 14 & more |

ACCIDENT

29. Date of accident ..../..... /..... 30. Time .....
31. Place of accident..... ... 32. District .....
32.2 Province .....
33. Date employee reported accident ...../ ...../..... 34. Time .....
35. What task was the employee performing at the time of the accident? .....
36. Period of experience in the task performed (years/months) ...../.....
37. 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)
38. 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 the machine/process involved, whether the injured person fell or was struck and all the factors contributing to the accident).
39. Was the accident a traffic accident on a public road? ..... | YES | NO |
40. Nature of injury sustained (eg index finger of right hand crushed) ....
Mark any of the following when applicable:..... | Killed | Amputation | Unconsciousness |
41. Are you satisfied that the employee was injured in the manner alleged by him? | YES | NO | If not, give reasons.
(If "no" state reasons on reverse side Part A page 3)
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PART A PAGE 2 MUST ALSO BE COMPLETED

Please complete in detail to ensure early finalisation.

Employer: …….. **Date of accident:** ……..

Employee: …… **Employee's ID no:** ……..

FURTHER PARTICULARS OF EMPLOYEE

42. Earnings of employee at the time of accident:
Attach copy of payslip as at 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 (ie 13th cheque) ……		
b) Other allowances (specify nature) ……		
Cash value of:		
Free food.....		
Free quarters.....		
Other payment in kind (specify nature) ……		

43. In terms of section 47 of the Act an employer is obliged to pay an employee full compensation for the first three months of absence

44. Are you prepared to make further compensation payments after the first three months from the date of the accident? YES NO

45. If you have already paid cash (earnings) to the employee, state the total amount R ……...

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

47. Number of days per week worked by the employee …….. ...

48. Date on which the employee ceased work due to accident …… .../……/…… 49. Time …….. ...

50. Did the employee complete his shift on the day that he ceased work? …… YES NO

51. Date on which the employee resumed work …… ./……. ./ …… 52. Time ……..

(If the employee will be off duty for an extended period, an interim Resumption Report (W.CI.6) must be submitted monthly).

53. If the employee was killed in the accident, state name and address of dependent of the employee. ……...

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FURTHER PARTICULARS (COMPULSORY)

54. 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. ……...

55. Was first aid given in this case? …… YES, NO

56. State the name of the medical practitioner/chiropractor who treated the employee. ……...

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

58. 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

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

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

b) Who was aware of the accident at the time... ……..

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

61. If the accident was investigated by the SA Police, state name of Police Station and docket number applicable ……...

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62. If motor vehicles were involved, furnish registration number/s and make and model……..

ANY ADDITIONAL DETAILS CAN BE SUPPLIED ON PART A PAGE 3

Employer: ..... **Date of accident:** .....

Employee: ..... **Employee's ID no:** .....

38. Continuation of point 38 of the previous page. Contributing factors/causes applicable. (Mark the applicable item/s at A and B).

A)

Defective plant	
Defective machine	
Unfavourable conditions of work	
Fault of employer	
Fault of injured employee	
Fault of supervisor	

B)

Railway	
Building work	
Electricity	
Chemicals	
Poisoning	
Burns	

Explosions	
Rotating machine	
Press/Rollers	
Woodworking machine	
Lifting machine	
Hand tools	

Other machinery (specify): .....

Any other contributing factors, not mentioned above (specify): .....

The rest of this page may be used for any additional details or comments regarding the accident.

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Was this an assault? YES NO **(COMPULSORY TO COMPLETE)**

Did the employee's spectacles break during the accident? YES NO

Was the employee's dentures damaged during the accident? YES NO

Road Accident? YES NO

Travelling on employer business?	YES NO
Traveling to training course/test/seminar on employer's instruction?	YES NO
Travelling to/from work?	YES NO
On callout	YES NO
On standby	YES NO
On public road?	YES NO
On private road?	YES NO

Additional info:

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