EMPLOYER'S REPORT OF AN ACCIDENT

(WCL. 2)

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT,1993

Section 6(A)(b) - Annexure 13

(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/her employment resulting in a personal injury for which medical treatment is required, or death.
2) Whenever an employee reports any personal injury to his/her employer, if in making the report the employee alleges that such an injury arose out of and in the course of his/her employment.

(Where the accident 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 Provincial Executive Manager 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 the 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/her 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 the 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
COMPENSATION HOUSE
CNR. SOUTPANSBERG AND HAMILTON ROAD
PO BOX 955
PRETORIA
0001

TELEPHONE: (012) 319-9111
(012) 323-8627
(012) 325-6686
(012) 326-7889
(012) 323-6986

Tollfree 0800 005392/3
e-mail info@wcomp.gov.za
Website http;//www.wcomp.gov.za

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 accidents.
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 Provincial Executive Manager 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).
6) If an injured employee should leave your employ, please keep record of the address where he/she can be reached so that monies which may be payable to him/her from the Compensation fund, can be sent to him/her with your assistance.

EMPLOYER:

EMPLOYEE: **DATE OF ACCIDENT:**

FURTHER PARTICULARS OF THE EMPLOYEE

42. Earnings of employee at the time of accident: Attach copy of pay slip 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 (i.e. 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 the 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 date of accident?

Yes	No

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

46. For what period were such payment made? From To

47. Number of days/hours worked by the employee

48. Date on which the employee ceased work 49. Time

50. Did the employee complete the shift on the day that he ceased to 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 dependant of the employee.

FURTHER PARTICULARS

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

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

(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)

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 Services, state the name of the Police station and docket number applicable

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

ANY ADDITIONAL DETAILS CAN BE SUPPLIED ON PART A PAGE 3

EMPLOYER'S REPORT OF AN ACCIDENT

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT,1993

Section 6(A)(b) - Annexure 13

Instructions:

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

(WCL. 2)

PART A PAGE 1

(For official use only)

Claim No……

DECLARATION BY EMPLOYER OR AUTHORIZED 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. 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.

9.1 Fax No
9.2 e-mail address
10. Situation of business/farm:
11. Nature of business, trade or industry

EMPLOYEE (CERTIFIED COPY OF IDENTITY DOCUMENT TO BE ATTACHED)

12. Is the injured employee 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. Tel No
27. Period in your employ (years/months)
28. Expected period of disablement (days) | 0-13 Days | 14 or more |

ACCIDENT

29. Date of accident
30. Time
31. Place of accident
32. District
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 of 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 the 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)

39. Was the accident a traffic accident on a public road? | Yes | No |
40. Nature of injury sustained. (e.g. 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 "no" state reasons on reverse side of Part A Page 3)

PART A PAGE 2 MUST ALSO BE COMPLETED, PLEASE.

EMPLOYER:

EMPLOYEE: **Date of accident:**

38. Continuation of point 35 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	

C)

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

EMPLOYER'S REPORT OF AN ACCIDENT

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PART B PAGE 1

Section 6(A)(b) - Annexure 13

(For official use only)

Claim No……

Instructions:

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

DECLARATION BY EMPLOYER OR AUTHORIZED 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. 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.

9.1 Fax No
9.2 e-mail address
10. Situation of business/farm:
11. Nature of business, trade or industry

EMPLOYEE (CERTIFIED COPY OF IDENTITY DOCUMENT TO BE ATTACHED)

12. Is the injured employee 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. Tel No
27. Period in your employ (years/months)
28. Expected period of disablement (days) | 0-13 Days | 14 or more |

ACCIDENT

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30. Time
31. Place of accident
32. District
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 of 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 the 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)

39. Was the accident a traffic accident on a public road? | Yes | No |
40. Nature of injury sustained. (e.g. 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 "no" state reasons on reverse side of Part A Page 3)

Instructions for medical practitioner/chiropractor or hospital on reverse side

EMPLOYER:

EMPLOYEE: **DATE OF ACCIDENT:**

FURTHER PARTICULARS OF THE EMPLOYEE

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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 |

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ANY ADDITIONAL DETAILS CAN BE SUPPLIED ON PART A PAGE 3