

EMPLOYER'S REPORT OF AN ACCIDENT

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

Section 6(A)(b) -Annexure 13

(W.Cl. 2)

(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 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 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
P.O. BOX 955
PRETORIA
0001

TELEPHONE: (012) 319-9111
FAX (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 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 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 might 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 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 (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 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 accident?

Yes

No

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

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

47. Number of days/hours per week worked by the employee

48. Date on which the employee ceased work / / 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.Cl.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 registration number/s

ANY ADDITIONAL DETAILS CAN BE SUPPLIED ON PART A PAGE 3

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Instructions:

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

(W.Cl. 2)
PART A PAGE 1

(For official use only)

Claim No.....

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.

WOR12/01/01

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. (.....) 10. Situation of business/farm:
- 9.2 e-mail address
11. Nature of business, trade or industry

EMPLOYEE (CERTIFIED COPY OF IDENTITY DOCUMENT TO BE ATTACHED)

12. Is the injured employee a
13. Surname 14. First names
15. ID No. 16. Date of birth/...../..... 17. Sex
18. Marital state

 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)

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?

(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 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?
40. Nature of injury sustained. (e.g. index finger of right hand crushed).....
Mark any of the following when applicable:
41. Are you satisfied that the employee was injured in the manner alleged by him?

(If "no" state reasons on reverse side of Part A Page 3)

PART A PAGE 2 MUST ALSO BE COMPLETED, PLEASE.

Please complete in detail to ensure early finalization.

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	

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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Instructions:

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

(W.Cl. 2)
PART B PAGE 1

(For official use only)

Claim No.

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. 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. (.....) 10. Situation of business/farm:
- 9.2 e-mail address
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
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13. Surname 14. First names
15. ID No. 16. Date of birth/...../..... 17. Sex

Male	Female
------	--------
18. Marital state

Married	Single
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 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
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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 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
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41. Are you satisfied that the employee was injured in the manner alleged by him?

Yes	No
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(If "no" state reasons on reverse side of Part A Page 3)

Please complete in detail to ensure early finalization.

Instructions for medical practitioner/chiropractor or hospital on reverse side

DIRECTIONS TO MEDICAL PRACTITIONER/CHIROPRACTOR/HOSPITAL

- (a) Only the Compensation Commissioner shall decide whether liability in respect of an accident should be accepted in terms of the provisions of the Act.
- (b) If liability is not accepted by the Compensation Commissioner medical expenses cannot be paid from the Compensation Fund.
- (c) The FIRST MEDICAL REPORT (W.CL. 4) must be completed in **duplicate** and care must be taken to ensure that the full names of the employee and employer and the employee's ID number as shown on this form, appear thereon. The original must be sent to the employer as soon as possible whilst the **duplicate must be kept by the medical practitioner/chiropractor or hospital together with this form.**
- (d) The medical practitioner/chiropractor or hospital must send a specified account to the employer. If the account is still **unpaid after 2 months this form together with the duplicate FIRST MEDICAL REPORT (W.CL.4)** and specified account must be sent under cover of an **Enquiry Regarding Unpaid Account (W.Cl.20)** to

THE COMPENSATION COMMISSIONER
COMPENSATION HOUSE
CNR. SOUTPANSBERG AND HAMILTON ROAD

P.O. BOX 955

PRETORIA

0001

TELEPHONE: (012) 319-9111

FAX (012) 323-8627

(012) 325-6686

(012) 326-7889

(012) 323-6986

Tollfree • 0800 005392/3

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Website • <http://www.wcomp.gov.za>

PROVINCIAL OFFICES: DEPARTMENT OF LABOUR

TOWN	POSTAL ADDRESS	STREET ADDRESS	TELEPHONE	FAX
Durban	PO Box 940	Salmon Grove Chambers 407 Smith Street	031-366 2000	031-305 2904
Cape Town	PO Box 872	Thomas Boydel Building, 22 Parade Street	021- 460 5033 021- 460 5044 021- 460 5008	021- 457 318
Bloemfontein	PO Box 522	National Health 43 Maitland Street	051-305 6248 051-505 6200	051-447 9353
Kimberley	P/Bag X5012	Cnr Compound & Pniel Roads	053-838 1500 053-838 1622	053-838 1620
Pretoria	PO Box 393	Frans du Toit Building, Cnr Paul Kruger & Schoeman Street	012-309 5286	012-309 5139
Johannesburg	PO Box 4560	Annuity House, 18 Rissk Street	011-497 3086 011-497 3283 011-497 3136	011-834 3050 011-497 3130
Mmbatho	P/Bag X2040	Provident House, University Drive, 2nd Floor Sebo Building	018-387 8100	018-384 2597
Witbank	P/Bag X7263	Labour Centre Building, Cnr Hofmeyer & Beatty Street	013-655 8700	013-655 8878
Polokwane (Pietersburg)	P/Bag X9368	42a Schoeman Street	015-290 1744	015-290 1670
East London	P/Bag X9005	3 Hill Street	043-701 3000	043-743 9719 043-743 2047