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MAYFAIR INSURANCE

WORKMEN'S COMPENSATION -INJURY REPORT

To be completed by the Employer in case injury to or death of a workman

1) THE EMPLOYER

a) Name: ……

b) Address: ……

c) Industry or business: ……

2) THE WORKMAN INVOLVED IN EMPLOYMENT INJURY

a) Name: ……

b) Address:(Home and permanent) ……

c) Sex: …… Age: ……

d) I.D No.: …… Occupation: ……

e) Workman's Job Description: ……

f) Was he casual or permanent: ……

g) Academic/Professional qualification/ Technical or trade test……

……

h) Was the injured workman in your direct employment? Yes/No……. If not, was he working at the place of the accident under the employment of a contractor or others?
State Details ……

i) Monthly or Daily earnings at the time of the accident……

j) Has the workman filed a suit Y/N…… Has the workman previously filed suit against you? (Y/N) …… If yes, give details of suits .....

3) THE ACCIDENT

a) Date & Hour: ……

b) Place: ……

c) Cause of the accident……

d) Was the workman recorded on duty at your workplace on the injury date……..

e) What duty was the workman assigned at the time of injury…….

If injury caused by Machinery: -

1. State name of machine & part causing the injury……

2. Was it fenced or guarded ……

3. Was it in motion when injury occurred?.....

4. Who was responsible for switching it on and off?.....

5. Who switched it on? ……..

6. His Address ……

7. His Permanent/Home Address if different from above ……

8. State exactly what the injured person was doing when he got injured ……

……

……

If injury not caused by machinery (e.g. Fire, a Fall, carrying heavy objects) name the cause and a brief description of how the workman got injured ……

……

……

Was the injured under the influence of alcohol/any drink or drugs at the time of the accident

……

4) THE INJURY

a) Was it fatal ……. If fatal give the names of all dependants of the deceased workman if known ……..

b) Particulars of injury (as certified by the Hospital/company's doctor) ……

…… are the injuries visible …….

c) State the probable period of disablement …….

d) Name the hospital/Dispensary/Private Clinic where he has been treated following the accident
…….

e) Whether admitted (Y/N) ……. Date when first treated ……

f) Date of admission …… Date of discharge …….

g) Attendance as out-patient prior to and/or subsequent to hospitalization……

From …… To ……

Was there a doctor's medical report? (Y/N) …… if yes, please provide copy

h) Amount expected on treatment …….

i) Who paid for it? ……

j) Was the injured recorded on an occurrence book/injury register ……. (Please attach copies)

k) Was there an LD 104 form filled(Y/N) …… if yes, please provide copy.

I) Has he returned to work? …….. When …….

5) OBSERVANCE OF INSRUCTIONS

a) Were there standing instructions/notices on how to do the assigned work?.....

……

……

……

b) Was the workman guilty of any misconduct or disobedience to such instructions or other procedures or rules? …… if so please give details

……

……

……

……

c) Whether the injured workman was provided with protective clothing/guards e.g. gloves, gumboots, helmets, goggles overall etc. (Y/N) …….. If yes, state the date of supply …… Did the work man sign for the gear …… If yes, please attach a copy of the signed register.

d) Was the workman found without the protective clothing/guards at the time of the accident? Yes/No…… if no, give reasons why …….

e) Had his immediate supervisor brought to the attention of the insured workman the necessity of wearing protective clothing/guards when the former saw the latter without these guards at the time of commencement of his work but before the occurrence on the date of the accident? .....

……..

……..

6) State the names, address (permanent & Home) of the persons who witnessed the accident:

a) ……..

……..

b) ……..

……..

c) ……..

……..

7. Brief statement/s from the above persons who witnessed the accident when it occurred:

a) ……

……..

……..

……..

Name……. Designation …….

Date …… Signature …….

b) ……

……..

……..

……..

Name……. Designation …….

Date …… Signature …….

c)) ……

……..

……..

……..

Name…….. Designation ……..

Date …… Signature ……..

The above details are factual to the best of my /our knowledge, information and belief.

(The below part must be completed)

(Please stamp here using the company's authorized stamp)

Date: ……..

Signature of Employer ……..

Name …… Designation ……..