

**GN 983 of 27 May 1994: Rules, forms and particulars which shall be furnished in terms of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No. 130 of 1993)  
(Government Gazette No. 15758)**

[These rules and forms were first published in GN 983 in *Government Gazette* 15758 of 27 May 1994 and have been amended by GNR.94 in *Government Gazette* 16230, by GN 1918 in *Government Gazette* 17620 of 22 November 1996, by GN 98 in *Government Gazette* 20855 of 11 February 2000, by GN 303 in *Government Gazette* 24938 of 28 February 2003, GN 120 in *Government Gazette* 25977 of 6 February 2004, by GN 278 in *Government Gazette* 27416 of 24 March 2005 and by GN 72 in *Government Gazette* 28433 of 27 January 2006.]

**as amended by**

<b>Notice</b>	<b>Government Gazette</b>	<b>Date</b>
R.94	16230	27 January 1995
1918	17620	22 November 1996
98	20855	11 February 2000
79	23057	29 January 2002
303	24938	28 February 2003
120	25977	6 February 2004
278	27416	24 March 2005
72	28433	27 January 2006
50	29555	26 January 2007
1236	30607	20 December 2007
241	31974	5 March 2009
268	33085	20 April 2010
150	34041	23 February 2011
197	36254	15 March 2013
268	37510	4 April 2014
358	37629	13 May 2014
385	38769	15 May 2015
444	39928	15 April 2016
117	40612	10 February 2017
379	41529	27 March 2018
514	42351	29 March 2019
476	43249	24 April 2020
242	44302	19 March 2021
133	44330	25 March 2021

I, Louis an Assen, Compensation Commissioner, hereby prescribe under [section 4 \(2\) \(e\)](#) of the Occupational Injuries and Diseases Act, 1993 (Act [No. 130 of 1993](#)), the following:

**ARRANGEMENT OF RULES**

<a href="#">1.</a>	Application for increased compensation [section 56]
<a href="#">2.</a>	Registration of Employer [ <a href="#">section 80</a> ]
<a href="#">3.</a>	Return of earnings [ <a href="#">section 82 (1)</a> ]
<a href="#">4.</a>	Notice of accident by the employer [section 39 (1) and (5)]
<a href="#">5.</a>	Notice of accident and claim for compensation [38 (1) and 43 (1)]
<a href="#">6.</a>	Notice of an occupational disease and claim for compensation [sections 65 (6) and 68 (1)]
<a href="#">7.</a>	Notice of an occupational disease by the employer [section 68 (2)]
<a href="#">8.</a>	Witnesses [sections 6 and 45]
<a href="#">9.</a>	Objection against decision of Commissioner [section 91]
<a href="#">10.</a>	Submission of medical reports [section 74]
<a href="#">11.</a>	Orders by Commissioner [sections 61 (1), 77 (2) and 87 (4)]
<a href="#">Form W.G. 30</a>	Application for additional compensation under section 56 of the Act
<a href="#">Form W.G. 28</a>	Subpoena
<a href="#">Form W.G. 29</a>	Objection against a decision of the commissioner
<a href="#">Form W Ac 60</a>	Order against an employer for the payment of assessment or other monies
<a href="#">Form W Ac 61</a>	Order against an employer individually liable or a mutual association for the payment of compensation or other pecuniary benefit owing to an employee
<a href="#">Form W.As. 2</a>	Registration of employer
<a href="#">Form W.As. 8</a>	Return of earnings
<a href="#">Form W CI 1 (E)</a>	Employer's report of an occupational disease
<a href="#">Form W CI 2 (E)</a>	Employer's report of an accident
<a href="#">Form W CI 3</a>	Notice of accident and claim for compensation
<a href="#">Form W CI 4</a>	First medical report and account for an accident
<a href="#">Form W CI 5</a>	Progress/Final medical report in respect of an accident
<a href="#">Form W CI 9</a>	Order against an employer in respect of the payment of a contribution by an employee towards the cost of medical aid
<a href="#">Form W CI 14</a>	Notice of an occupational disease and claim for compensation
<a href="#">Form W CI 22</a>	First medical report in respect of an occupational disease

**1. Application for increased compensation (section 56).**-An application for increased compensation shall be submitted to the Commissioner on Form W G 30 (Annexure 1) with the particulars required therein and such other information and documents as the applicant may consider necessary.

Rules to facilitate the consideration of applications under section 56.

In these rules a word or expression to which a meaning has been assigned in the Act shall have that meaning and, unless the context indicates otherwise-

**"applicant"** means the person making application;

**"application"** means an application in terms of section 56 of the Act for increased compensation;

**"the Act"** the Compensation for Occupational Injuries and Diseases Act, 1993 (Act [No. 130 of 1993](#)), and also the Workmen's Compensation Act, 1941 (Act [No. 30 of 1941](#));

**"respondent"** means-

- (a) in the cases where the compensation fund is liable for the payment of compensation-
  - (i) the Legal Officer or any other person appointed by the Commissioner; and
  - (ii) as second respondent, the employer of the employee concerned unless the said employer has notified the Commissioner that he does not intend to intervene in the matter or fails to comply with [paragraph \(f\)](#) of these rules;
- (b) in the case where a mutual association is liable for the payment of compensation-
  - (i) the mutual association; and
  - (ii) as second respondent, the employer of the employee concerned unless the said employer has notified the Commissioner that he does not intend to intervene in the matter or has failed to comply with [paragraph \(f\)](#) of these rules;
- (c) in the case where an employer referred to in section 84 (1) (a) (i) of the Act is liable for the payment of compensation, the person concerned mentioned in section 39 (2) of the Act;
- (d) in any other case where an employer individually liable is liable for the payment of compensation, such employer.
- (e) The Commissioner shall as soon as practicable after an application has been submitted to him send a copy thereof to the employer in question and, where appropriate, the mutual association.
- (f) Within three months after a copy has so been sent, every respondent shall deliver a document to the Commissioner and the applicant in which he states-
  - (i) whether he contests the application and, if so,
  - (ii) which allegations by the applicant he admits and which allegations he denies, together with such explanations and information that he may deem relevant.
- (g) The applicant shall within three months after the document referred to in [paragraph \(f\)](#) has been delivered to him deliver a document to the Commissioner and every respondent in which he states-
  - (i) whether he intends to proceed with his application and, if so,
  - (ii) which allegations by the respondent he admits and which allegations he denies, together with such explanations and information that he may deem relevant.
- (h) The Commissioner may at any time request any party to supply further particulars and such party shall within the period determined by the Commissioner deliver a document with such particulars to the Commissioner.
- (i) The Commissioner may at any time permit any party to amend or supplement any allegation, explanation or information in terms of [paragraphs \(f\), \(g\) or \(h\)](#) of these rules.
- (j) The Commissioner may at any time extend the period prescribed by [paragraphs \(f\), \(g\) or \(h\)](#) or determined in terms of [paragraph \(h\)](#) of these rules.
- (k) If the Commissioner decides upon a formal hearing, he shall send a document to every party in which-
  - (i) he sets out the facts which have been admitted and for which there is *prima facie* evidence in his opinion;
  - (ii) he formulates the issue.
- (l) The Commissioner may at any time before or during the hearing of his own accord or on application by one of the parties amend the formulation of the issue.

- (m) A formal hearing shall not be set down or be proceeded with earlier than 30 days after the dispatch of the documents referred to in [paragraph \(k\)](#) of these rules or the amendment of the formulation of the issue as contemplated in [paragraph \(l\)](#), save with the consent of all the parties.

**2. Registration of Employer [section 80].**-The Registration of Employer shall be on Form W.As. 2 [Annexure A] with the particulars required therein, as the case may be, and this form will not be posted to registered employers and is obtainable from <http://www.labour.gov.za>

All employers are encouraged to file online as per link <http://www.labour.gov.za>

(Editorial Note: Wording as per original *Government Gazette*. It is suggested that the phrase "Annexure A" is intended to be "Annexure 7".)

[[R. 2](#) substituted by GN 358 of 13 May 2014.]

(Editor's note: Please note that Notice GN 358 of 13 May 2014 instructs an amendment of item 3. We suggest that it amends item 2 which regards Registration of Employer and not item 3 which regards Return of Earnings.)

**3. Return of earnings (section 82 (1)).**-"The Return of Earnings shall be on Form W.As. 8 (Annexure A) with the particulars required therein, as the case maybe", and this form will not be posted to registered employers and is obtainable from <http://www.labour.gov.za>.

All employers are encouraged to file on line as per link <http://www.labour.gov.za>.

(Editorial Note: Wording as per original *Government Gazette*. It is suggested that the phrase "Annexure A" is intended to be "Annexure 8".)

[[R. 3](#) substituted by GNR.94 of 1995, by GNR.1918 of 1996, by GNR.98 of 2000, by GN 79 of 2002, by GN 303 of 2003, GN 120 of 2004, by GN 278 of 2005, by GN 72 of 2006, by GN 50 of 2007, by GN 1236 of 2007, by GN 241 of 5 March 2009, by GN 268 of 20 April 2010, by GN 150 of 23 February 2011, by GN 197 of 15 March 2013, by GN 268 of 4 April 2014, by GN 385 of 15 May 2015, by GN 444 of 15 April 2016, by GN 117 of 10 February 2017, replaced by GN 379 of 27 March 2018 and by GN 514 of 29 March 2019.]

**4. Notice of accident by the employer [section 39 (1) and (5)].**-An accident shall be reported to the Commission in terms of section 39 (1) and (5) of the Act submitting Form W CI 1 (E) (Annexure 13) to the Commissioner or the mutual association with the particulars required therein as the case may be.

**5. Notice of accident and claim for compensation [sections 38 (1) and 43 (1)].**-Notice of an accident and claim for compensation in terms of sections 38 (1) and 43 (1) of the Act shall be given by or on behalf of an employee to the employer or mutual association or the Commissioner as the case may be by submitting Form W CI 3 (Annexure 14) with the particulars required therein.

**6. Notice of an occupational disease and claim for compensation [sections 65 (6) and 68 (1)].**-(i) Notice of an occupational disease or a claim for compensation shall be lodged by submitting to the employer, Commissioner or mutual association Form W CI 14 (Annexure 18) with the particulars required therein, together with such other documents that may be regarded as necessary to corroborate the claim.

(ii) If the claimant becomes aware of information or acquires possession of a document which in his opinion is relevant for the decision of the claim and which is not at the disposal of the Commissioner, he shall forthwith lay such information or document before the Commissioner.

**7. Notice of an occupational disease by the employer [section 68 (2)].**-Notice of an occupational disease shall be given in terms of section 68 (2) to the Commissioner or mutual association as the case may be by submitting Form W CI 1 (E) (Annexure 12) with the particulars required therein.

**8. Witnesses [sections 6 and 45].**-(i) A subpoena in terms of section 6 or 45 of the Act shall be on Form W G 28 (Annexure 2) and shall be signed by the Commissioner.

(ii) A subpoena can be served on the person to whom it is addressed-

- (a) by delivering a copy thereof to him;
- (b) by leaving a copy thereof at his place of abode, business or employment with some person apparently not less than 16 years of age and apparently residing or employed there; or

- (c) by dispatching a copy thereof to him by registered or certified post at his place of abode, business or employment, or to his post office box number.

**9. Objection against decision of Commissioner [section 91].**-An objection against a decision of the Commissioner shall be submitted on Form WG 29 (Annexure 3) with the particulars required therein.

**10. Submission of medical reports [section 74].**-(1) A medical report in respect of an accident shall be on Form W CI 4 (Annexure 15) and shall be posted to the employer with the particulars required therein.

(2) A medical report in respect of an occupational disease shall be on Form W CI 22 (Annexure 19) and shall, with the particulars required therein, be posted to the employer or, where applicable, submitted to the Commissioner.

(3) When so required further medical reports in respect of an accident shall be submitted monthly on Form W CI 5 (Annexure 16) to the Commissioner or the mutual association or employer individually liable concerned, as the case may be.

(4) When so required further medical reports in respect of an industrial disease shall be submitted monthly on Form W CI 26 (Annexure 20 ) to the Commissioner or the mutual association or employer individually liable concerned, as the case may be.

**11. Orders by Commissioner [sections 61 (1), 77 (2) and 87 (4)].**-Orders by the Commissioner under sections 61 (1), 77 (2) and 87 (4) shall be on Forms W Ac 61 (Annexure 5), W CI 9 (Annexure 17) and W Ac 60 (Annexure 4), respectively, and shall be signed by him.

*Other particulars*

Notification of name of responsible person [section 39 (3)].

The Commissioner shall be notified in writing of the full name, postal address, telephone and fax number of the responsible person.

*Notice of formal hearing [section 45 (2)]*

The Commissioner shall notify the claimant in writing of the date, time and place of the formal hearing.

**Form W.G. 30**

APPLICATION FOR ADDITIONAL COMPENSATION UNDER SECTION 56 OF THE ACT

**W.G.30**

**APPLICATION FOR ADDITIONAL COMPENSATION  
UNDER SECTION 56 OF THE ACT**

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

(Previously Workmen's Compensation Act, 1941)

**(Section 56-Commissioner's rules, forms and particulars-Annexure 1)**

*N.B.*- If the space on this form is inadequate for the reply to any question, the words "statement attached" may be inserted under the relative item and statement containing the required particulars should be attached. Every such statement should bear sufficient details to identify it with the application and with the item to which it refers.

***PARTICULARS OF APPLICANT***

- (1) Name of applicant
- (2) Address of applicant
- (3) (To be completed only if the accident/occupational disease results in death). State the relationship of the applicant to the deceased employee.
- (4) Name of employee
- (5) Name of employer
- (6) Date of accident/occupational disease
- (7) Place of accident/where occupational disease occurred

**PARTICULARS OF COMPENSATION AWARDED**

- (8) Has any compensation already been awarded in respect of-
- (a) Permanent disablement? ; or
  - (b) Death?
- If so, give details

**GROUNDS OF APPLICATION  
 Negligence-Section 56 (1)**

- (9) Is it alleged that the accident/occupational disease was due to the negligence of a person referred to in section 56 (1)? (Yes or No)
- (10) If so furnish the following particulars in respect of the person(s) whose negligence is alleged to have caused the accident/occupational disease:

Name	Capacity in which Employed	State whether this person falls under subparagraph (a), (b), (c), (d) or (e) of section 56 (1) of the Act

- (11) Give details of the alleged negligence of the above person(s):

Name	Details

**Patent Defect.-Section 56 (2)**

- (12) Is it alleged that the accident/occupational disease was due to a patent defect as set out in Section 56 (2) (Yes or No)
- (13) If so-
- (a) Did the patent defect exist in the *premises, works, material or machinery* used in the business of the employer? (State which and give details)
  - (b) Furnish the following particulars in respect of the person(s) alleged to have knowingly or negligently caused or failed to remedy the patent defect:-

Name	Capacity in which Employed	State whether this person falls under subparagraph (a), (b), (c), (d) or (e) of section 56 (1) of the Act

- (14) State on what grounds it is alleged that the above person(s) knowingly or negligently caused or failed to remedy the patent defect:

Name	Grounds

**WITNESSES**

- (15) Give the following particulars in respect of witnesses whom the applicant wishes to be subpoenaed to give evidence in support of the application should a formal hearing be held:

Name	Addresses

(16) State briefly the nature of the evidence which each witness will be able to give:

Name	Evidence

**REPRESENTATION**

(17) State the name and address of the trade union, attorney or other representative (if any) who will act for the applicant in this matter

**DECLARATION**

I, \_\_\_\_\_ being the applicant in this matter, do hereby declare that the above particulars are correct to the best of my knowledge and belief.

Signed at ..... on this ..... day of ..... 19.....

*Signature*

Witness:  
Date

**Form W.G. 28  
SUBPOENA**

**W.G.28**

**SUBPOENA**

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

(Previously Workmen's Compensation Act, 1941)

**(Section 6 of 45-Commissioner's rules, forms and particulars-Annexure 2)**

To

You are hereby required to appear in person before the Compensation Commissioner or his duly authorised representative at \_\_\_\_\_ on the \_\_\_\_\_ at ..... a.m./p.m. to give evidence in the matter of \_\_\_\_\_ 19 and to bring with you the documents specified in the list hereunder:

List of documents to be produced:

Date.	Description.	Original or Copy.

Given under my hand at ....., this ..... day of ..... 19.....

*Compensation Commissioner.*

**Form W.G. 29  
OBJECTION AGAINST A DECISION OF THE COMMISSIONER**

**W.G.29**

**OBJECTION AGAINST A DECISION OF THE COMMISSIONER**

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

(Previously Workmen's Compensation Act, 1941)

**[Section 91-Commissioner's rules, forms and particulars-Annexure 3]**

(This objection must be lodged in duplicate with the Compensation Commissioner, P.O. Box

955, Pretoria, 0001, within 90 days of the Commissioner's decision.)

**(N.B.:** "lodged within 90 days" means that the objection must reach the Commissioner within 90 days from the date of his decision.)

**NOTICE OF OBJECTION**

Name of employee

Name of employer

1. State name of objector

Address

Postal Code

2. State whether objector is-

(a) the employee

or

(b) the employer

or

(c) an employers' organisation or trade union of which the person in respect of whom the decision was given, was at the times concerned a member

[**Note:** The word "Yes" should be written against (a) or (b) or (c), whichever is applicable.]

3. Quote the reference number and date of the document containing the Commissioner's decision against which the objection is lodged.

Reference No.

Date

4. State fully what portion of the Commissioner's decision you object to:

5. Give your reasons in full for lodging the objection:

6. Any documentary evidence (or copies thereof) that you wish to submit in support your contention(s) as stated in paragraph 5 should be attached and enumerated as hereunder:

Number	Title or description of document
(i)	
(ii)	
(iii)	
(iv)	

7. Give names and addresses of persons whom you wish to have called as witnesses to give evidence in support of your objection:

Name	Address
(i)	
(ii)	
(iii)	
(iv)	

8. State briefly the points on which they will give evidence:

(i)
(ii)
(iii)
(iv)

Place:  
Date:

*Signature of objector*

**Form W Ac 60**

ORDER AGAINST AN EMPLOYER FOR THE PAYMENT OF ASSESSMENT OR OTHER MONIES

**W Ac 60**

**ORDER AGAINST AN EMPLOYER FOR THE  
PAYMENT OF ASSESSMENT OR OTHER MONIES**

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

(Previously Workmen's Compensation Act, 1941)

**[Section 87 (4)-Commissioner's rules, forms and particulars-Annexure 4)**

ORDER FOR THE PAYMENT OF MONEY DUE TO THE COMMISSIONER

Whereas \_\_\_\_\_ (employer) of  
address \_\_\_\_\_  
(District)

has failed to pay the amount to \_\_\_\_\_ in respect of an  
assessment in terms of section 86 of this Act, an instalment/a penalty in terms of section  
87/other monies payable in terms of the Act;

And whereas the mentioned \_\_\_\_\_ employer  
refuses or delay to pay the said amount to

Therefore, it is hereby ordered in terms of section 87 of the Act that the said debtor  
(employer) do forthwith pay the mentioned amount to me.

Given under my Hand at Pretoria this ..... day of .....  
19.....

*Compensation Commissioner.*

**Form W Ac 61**

ORDER AGAINST AN EMPLOYER INDIVIDUALLY LIABLE OR A MUTUAL ASSOCIATION FOR THE PAYMENT OF  
COMPENSATION OR OTHER PECUNIARY BENEFIT OWING TO AN EMPLOYEE

**W Ac 61**

**ORDER AGAINST AN EMPLOYER INDIVIDUALLY LIABLE OR A MUTUAL  
ASSOCIATION FOR THE PAYMENT OF COMPENSATION OR  
OTHER PECUNIARY BENEFIT OWING TO AN EMPLOYEE**

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

(Previously Workmen's Compensation Act, 1941)

**[Section 61 (1)-Commissioner's rules, forms and particulars-Annexure 5)**

Claim No. \_\_\_\_\_ District \_\_\_\_\_  
Whereas \_\_\_\_\_ (name of employer individually liable or mutual association)  
of \_\_\_\_\_ is liable to pay the amount of R \_\_\_\_\_  
which is money that is due as compensation or a benefit in terms of this Act in respect of \_\_\_\_\_ ;

And whereas the said \_\_\_\_\_ (employer  
individually liable or mutual association) refuses or fails to pay such compensation of  
benefit;

Therefore, it is hereby ordered in terms of section 61 (1) of the Act that the said  
(employer individually liable or mutual association) do forthwith pay the  
mentioned amount to me.

Given under my Hand at Pretoria this ..... day of .....  
19.....

*Compensation Commissioner.*

**Form W.As. 2**

REGISTRATION OF EMPLOYER





**5.1 Estimated earnings of employees to be furnished as from the date furnished in item 1.1 up to end of February the next year**

5.1.1	Number of employees presently employed _____	<input type="text"/>
5.1.2	Average number of employees expected to be employed during the above-mentioned period	<input type="text"/>
5.2	Estimated earnings expected to be paid to employees up to a maximum of R 332 479 per person per annum for the period (01 March 2014 to 28 February 2015):	<b>RANDS ONLY</b> <input type="text"/>
5.2.1	Total estimated earnings of employees _____	<input type="text"/> 00
5.2.2	Total estimated cash value of food and lodging provided free by employer _____	<input type="text"/> 00
5.2.3	Estimated cash value of other in-kind benefits _____	<input type="text"/> 00
5.2.4	Estimated earnings of working directors of a Co or working members of a CC Refer to item 5.2 i.r.o. maximum earnings	<input type="text"/> 00
<b>Provide the estimated earnings of items 5.2.1 to 5.2.4 and give the total under 5.3:</b>		<input type="text"/> 00
<b>5.3 Total estimated earnings from: _____ to: _____</b>		<input type="text"/> 00

**PART 6 ADDITIONAL INFORMATION IN RESPECT OF HEAD OFFICE AND/OR FILIALS / BRANCHES**

6.1 Furnish the trading name and postal address of the Head Office and/or filial / branches and if already registered, the registration number allocated by the Unemployment Insurance Fund (UIF) and/or the Compensation Fund (CF).

6.2 Kindly furnish your bank details by completing the section below. This information is required for the purpose of a direct electronic deposit to your bank account IF applicable. Direct deposits prevent postal delays and cheque fraud.

Bank: \_\_\_\_\_ Branch Name: \_\_\_\_\_ Branch Code:

Type of Account: \_\_\_\_\_ Account number:

Name of Account Holder: \_\_\_\_\_

**PART 7 DECLARATION BY EMPLOYER OR AUTHORISED PERSON**

I certify that the above particulars are correct.

NAME (PRINTED)	SIGNATURE	POSITION/CAPACITY
CONTACT PERSON: _____	TEL NO: ( ) _____	DATE
	CELL NO _____	

**Form W.As. 8**

**RETURN OF EARNINGS**

[Form W.As. 8 amended by GN 79 of 2002 and by GN 303 of 2003, substituted by GN 120 of 2004, by GN 278 of 2005, by GN 72 of 2006, by GN 50 of 2007, by GN 1236 of 2007, by GN 241 of 5 March 2009, by GN 268 of 20 April 2010, by GN 150 of 23 February 2011, by GN 197 of 15 March 2013, by GN 268 of 4 April 2014, by GN 385 of 15 May 2015, by GN 444 of 15 April 2016 and by GN 117 of 10 February 2017 and replaced by GN 379 of 27 March 2018, by GN 514 of 29 March 2019 and by GN 476 of 24 April 2020, by GN 242 of 19 March 2021 and by GN 133 of 25 March 2021.]



**employment & labour**  
Department  
Employment and Labour  
REPUBLIC OF SOUTH AFRICA



**CF 2A: COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT 130 OF 1993**

**RETURN OF EARNINGS**

**Section A - Employer's details**

Name of Employer

CF Registration No 9 9

UIF Registration No

CIPC Registration No

SARS Tax No

Business Address

City/Town

Province

Postal Address

Code

Employer Telephone No

Mobile Telephone No

Employer's email address

Consultant's email address

Consultant's Telephone No

**SECTION B: Declaration of Earnings**

**CF Registration number:99**

<b>Actual Earnings: 01/03/2020 - 28/02/2021</b>				<b>Provisional Earnings: 01/03/2021 - 28/02/2022</b>				
<b>Month</b>	<i>Number of <b>employees</b> and amount of <u>earnings (staff costs/salaries &amp; wages)</u> per month paid to all employees (excluding directors of a Company or members of a close corporation) up to a <b>maximum of R 484 200</b> per person for the above period.</i>		<i>Number of <b>directors/members</b> and amount of <u>earnings (staff costs/salaries &amp; wages)</u> per month paid to directors of a Company or members of a Close Corporation up to a <b>maximum of R 484 200</b> per person for the above period.</i>		<i>Number of <b>employees</b> and amount of <u>earnings (staff costs/salaries &amp; wages)</u> per month expected to be paid to all employees (excluding directors of a Company or members of a close corporation) up to a <b>maximum of R 506 473</b> per person for the above period.</i>		<i>Number of <b>directors/members</b> and amount of <u>earnings (staff costs/salaries &amp; wages)</u> per month expected to be paid to directors of a Company or members of a Close Corporation up to a <b>maximum of R 506 473</b> per person for the above period.</i>	
	<b>Num-ber of emplo-yees</b>	<b>Earnings - (Rands only)</b>	<b>Num-ber</b>	<b>Earnings - (Rands only)</b>	<b>Num-ber of emplo-yees</b>	<b>Earnings - (Rands only)</b>	<b>Num-ber of emplo-yees</b>	<b>Earnings - (Rands only)</b>
<b>Mar</b>								
<b>Apr</b>								
<b>May</b>								
<b>Jun</b>								
<b>Jul</b>								
<b>Aug</b>								
<b>Sep</b>								
<b>Oct</b>								
<b>Nov</b>								
<b>Dec</b>								
<b>Jan</b>								

<b>Feb</b>							
<b>Total</b>							
			<b>FINAL EARNINGS PAID</b>	<b>ESTIMATED EARNINGS</b>			
<b>Total earnings of both employees and Directors/Members:</b>							
<b>Total cash value of free food and/ or quarters. (if applicable) in Rands.</b>							
<b>GRAND TOTAL OF EARNINGS</b>							
<b>State in words the grand total of earnings:</b>				<b>State in words the grand total of earnings:</b>			

**SECTION C: Declaration of Oath**

**CF Registration number:99**

*I confirm that the information given in this form is true, complete and accurate:  
Any information submitted may be subjected to verification. Information submitted knowingly is false may result in a legal action by the Compensation Commissioner.  
If an error is detected after submitting your Return of Earnings, you have 60 days from the date assessed to apply for the revision of assessment. The request must be forwarded to [cfrevision@labour.gov.za](mailto:cfrevision@labour.gov.za) or call 0860 105 350 for assistance.*

**Declaration by the Employer:**

**Name & Surname:**

**Designation/Capacity:**

**Signature:**

**Date:**

**Telephone No:**

**e-mail address:**

*Declaration by the Consultant*

**OR If using a service of a consultant (attach a Power of Attorney and complete)**

**Name & Surname:**

**Consultant's Company Name**

**Signature:**

**Date:**

**Telephone No:**

**e-mail address:**

**Registered Professional Body & Practise No.**

**For Office Use Only**

**Form W CI 1 (E)**  
EMPLOYER'S REPORT OF AN OCCUPATIONAL DISEASE

**W CI 1 (E)**

**EMPLOYER'S REPORT OF AN OCCUPATIONAL DISEASE**

For office use only

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

Claim No.....

**Section 4 (2) (e)-Annexure 12**

DECLARATION BY EMPLOYER OR AUTHORISED PERSON

I hereby declare that the particulars, shown in items 1 to ..... of this report, of an alleged occupational disease contracted by the employee, 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. (...)
9. Fax (...)
10. Situation of business/farm
11. Nature of business, trade or industry

EMPLOYEE

12. Surname
13. First names
14. Id. No.
15. Date of Birth ..../..16. Sex male/female
17. Marital state married/single
18. Citizen of
19. Personnel No.
20. Occupation
21. Street address
22. Postal code
23. Period in your employ (years/months)
24. Is the injured employee a working director, working member of a CC, owner of or a partner in the business?

OCCUPATIONAL DISEASE

25. Nature of disease
26. Date the disease was diagnosed
27. Alleged cause of disease

(State the agent present in the work-place and with which he had contact that caused the disease)

28. For how long a period was he exposed
29. Date employee reported the disease
30. Please mention the name and address of the employer if the employee did not contract the disease in your employment

31. What type of work was the employee performing with the other employer

OTHER PARTICULARS OF EMPLOYEE

32. Earnings of employee at the time of the diagnosis of the disease  
Gross cash earnings  
(Including average payments for overtime and/or commission of a constant character)  
Allowance of a recurrent nature:

R/week	R/month

(a) Bonuses (i.e. 13th cheque)  
 (b) Other allowances (specify nature)  
 Cash value of free food  
 Cash value of free quarters

33. Will the employee during temporary total disablement continue to receive from you:  
 Free Food? Yes/No Free quarters? Yes/No
34. Are you prepared to make cash payments during temporary total disablement that lasts longer than three months?  
 Yes/No
35. If you have already paid cash to the employee, state the total amount R
36. For what period were such payments made? From ...../...../..... To ...../...../.....
37. Date on which the employee ceased work ...../...../..... Time.....
38. Did the employee complete his shift on the day of the accident? Yes/No
39. Date on which the employee resumed work  
 [If employee has not yet resumed work, a Resumption Report (W CL 6) must be submitted as soon as he resumes duty.]

**FURTHER PARTICULARS**

40. If the employee did to your knowledge receive compensation previously or the same disease or another disease or in respect of an accident, received compensation for permanent disablement, give full particulars
41. Was the disease caused by the employee's-  
 (a) Deliberate non-compliance of 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 diseases  
 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.)

**Form W CI 2 (E)**  
 EMPLOYER'S REPORT OF AN ACCIDENT

**EMPLOYER'S REPORT OF AN ACCIDENT**

**W CI 2 (E)**

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 (ACT [NO. 130 OF 1993](#))  
 [Section 39 (1) and (5)-Commissioner's rules, forms and particulars-Annexure 13]

PART A PAGE 1

For office use only
Claim No.....

**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 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. (...)
9. Fax (...)
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 or a partner in the business?
13. Surname
14. First names
15. Id. No. 

Male	Female
------	--------
16. Date of Birth.../.../...
17. Sex
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 and 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 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)  
 35. Short description of how the accident occurred. (**ALSO** mark the applicable items on reverse side and use the reverse side for a full description.)

(Refer to the machine/process involved and 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/ies 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

PART A PAGE 2 MUST ALSO BE COMPLETED, PLEASE

PART A PAGE 3

**ADDITIONAL DETAILS OR COMMENTS**

This page may be used for any additional details or comments regarding the accident.

35. 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 con- ditions of work	
Fault of employer	
Fault of injured employee	
Fault of supervisor	

(B)

Railway	
Building work	
Electricity	
Chemicals	
Poisoning	
Burns	

Explosions	
Rotating machine	
Press/Rolls	
Woodworking machines	
Lifting machines	
Hand tools	

Other machinery (specify)

Any other contributing factors, not mentioned above (specify)

**FURTHER PARTICULARS OF EMPLOYEE**

39. Earnings of employee at the time of the accident:	R/week	R/month
Gross cash earnings (Including average payments for overtime and/or commission of a constant character)		
Allowance of a recurrent nature:		
(a) Bonuses (i.e. 13th cheque)		
(b) Other allowances (specify nature)		
Cash value of free food		
Cash value of free quarters		

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 payment 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 of the accident?  Yes  No

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

49. Time.....

(If employee has not yet assumed work, a Resumption Report (W CI 6) must be submitted as soon as he resumes duty.)

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

**FURTHER PARTICULARS**

51. Should the employee, to your knowledge, have any physical defect, suffer 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 treated the employee, state name of the practitioner

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 the police station

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

ANY ADDITIONAL DETAILS CAN BE SUPPLIED ON PART A PAGE 3.



[Section 39 (1) and (5)-Commissioner's rules, forms and  
particulars-Annexure 13]

For office use only

Claim  
No.....

**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 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. (...)
9. Fax (...)
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 or a 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 and 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 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)
35. Short description of how the accident occurred. (ALSO mark the applicable items on reverse side and use the reverse side for a full description.)

(Refer to the machine/process involved and 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 no, give reasons

Instructions for practitioner or hospital on reverse side

**NOTICE OF ACCIDENT AND CLAIM FOR COMPENSATION**  
 COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES, 1993  
 (ACT [NO. 130 OF 1993](#))

(Previously Workmen's Compensation Act, 1941)

**[Section 38 (1) and section 43 (1)-Commissioner's rules, forms and particulars-  
Annexure 14]**

**1. EMPLOYEE**

Surname (Capital letters)

First names (Capital letters)

Id. No.

Personnel No.

Residential address

Postal Code

Occupation Date of birth Sex Marital status

	Male	Female	Married	Not married
--	------	--------	---------	-------------

**2. EMPLOYER**

Name of employer in who's service the accident was contracted

Address

**3. ACCIDENT**

- (i) When and where did the accident occur?  
 Date Time Place
- (ii) What was the workman doing at the time and how did the accident occur?
- (iii) Describe in detail the nature and extent of the injury
- (iv) Did anybody see the accident happen?  
 If so, specify: Name Address

**4. THE EMPLOYEE'S EARNINGS AT TIME OF ACCIDENT**

	Per week R	Per month R
Gross cash earnings (including average overtime and/or commission of a regular nature)		
Allowance of a regular nature:		
(a) Bonuses (eg. 13 <sup>th</sup> cheque)		
(b) Other (specify)		
Cash value of quarters		
Cash value of food		

5. (a) If the accident resulted in the DEATH of the employee, the following information relating to his dependants, on whose behalf the claim is made, should be given:

Full name	Address	Date of birth	Relationship with employee

- (b) In the case of all OTHER accidents, the following information should be furnished in regard to next-of-kin of the employee:

Full name	Address	Relationship

I certify that the information in this form is to the best of my knowledge correct.

Date

**Form W CI 4**  
FIRST MEDICAL REPORT AND ACCOUNT FOR AN ACCIDENT

**W.CI.4**

**FIRST MEDICAL REPORT AND ACCOUNT FOR AN ACCIDENT**  
COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES, 1993  
(ACT [NO. 130 OF 1993](#))

(Previously Workmen's Compensation Act, 1941)

**[Section 74 (1)-Commissioner's rules, forms and particulars-Annexure 15]**

Claim No.

\_\_\_\_\_  
Surname of employee  
First name(s)  
Address  
Name of employer  
Address

1. Date of accident \_\_\_\_\_ Date of your first consultation \_\_\_\_\_
2. How did the alleged accident happen?
3. Full clinical description of injury(ies) (Not symptoms, signs or syndromes):
  
4. Describe briefly any pre-existing defect of accident-dates:
  
5. X-Rays: Date \_\_\_\_\_ By whom \_\_\_\_\_  
**(Attach report if available)**
6. Surgical operations or reduction: Date \_\_\_\_\_ By whom \_\_\_\_\_
  
7. Anaesthetics General \_\_\_\_\_ Duration \_\_\_\_\_ Local \_\_\_\_\_ By whom \_\_\_\_\_
8. (a) Consultation Yes/No \_\_\_\_\_ With whom \_\_\_\_\_ Date \_\_\_\_\_  
(b) Did you order physiotherapy?  
Yes/No \_\_\_\_\_  
Physiotherapist \_\_\_\_\_
9. (a) Is employee unfit for his/her work? Yes/No \_\_\_\_\_  
(b) Possible date fit for: Light duty \_\_\_\_\_ Normal duty \_\_\_\_\_

\*\*Account in respect of first consultation and or procedure(s)

Your Account No.:

PR No.:

Description of service	Place and dates of treatment or visits	Item of Tariff	R	c

I certify that I have by examination, satisfied myself that the injury(ies)/condition of the employee is the result of the accident as described above.

Date (important)

*Signature of medical  
practitioner/chiropractor*

Name (printed):  
registered address:

**N.B.:** This report must be sent to the employee's employer within 14 days after the first consultation.

\*\* Please submit separate accounts for further services.

**PROGRESS/FINAL MEDICAL REPORT IN RESPECT OF AN ACCIDENT**

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

(Previously Workmen's Compensation Act, 1941)

**[Section 74 (2)-Commissioner's rules, forms and particulars-Annexure 10]**

Claim No.

Surname of Employee

(Block letters)

Christian names

Address

Name of employer

Address

Date of accident

1. Describe any operation(s)/procedures/tests carried out and date(s)
  
2. Prognosis and further treatment?
  
3. (a) From what date has the employee been fit for his normal work?  
 or  
 (b) On what date is he likely to be fit for his normal work?
  
4. Has the employee's condition become stabilised?  
 If so, describe in detail any permanent anatomical defect and/or impairment of functions as a result of the accident

Account in respect of consultation and/or procedure(s)

Your Account No.:

PR No.:

Description of service	Place and dates of treatment or visits	Item of Tariff	R	c

I certify that I have by examination, satisfied myself that the injury(ies)/condition of the employee is the result of the accident as described above.

Date (important)

*Signature of medical practitioner/chiropractor*

Name (printed):

Registered address:

**N.B.:** This report must be submitted on a monthly basis to the Compensation Commissioner or mutual association or employer individually liably as the case may be until the employee's condition has become stabilised when a final medical report should be submitted.

**Form W CI 9**

ORDER AGAINST AN EMPLOYER IN RESPECT OF THE PAYMENT OF A CONTRIBUTION BY AN EMPLOYEE TOWARDS THE COST OF MEDICAL AID

**ORDER AGAINST AN EMPLOYER IN RESPECT OF THE PAYMENT OF A CONTRIBUTION BY AN EMPLOYEE TOWARDS THE COST OF MEDICAL AID**

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

(Previously Workmen's Compensation Act, 1941)

**[Section 77 (2)-Commissioner's rules, forms and particulars-Annexure 17]**

Claim No. \_\_\_\_\_ District \_\_\_\_\_  
Whereas \_\_\_\_\_ (employer)  
to \_\_\_\_\_ (address) guilty of an offence in terms of section 77 (1)  
of the Act in that he received from the ..... (employee) R.....  
(amount)  
a contribution towards the cost of medical aid.

Therefore, it is hereby ordered in terms of section 77 (2) of the Act that the said  
\_\_\_\_\_ (employer) do forthwith pay the mentioned amount to me.

Given under my Hand at Pretoria this \_\_\_\_\_ day of \_\_\_\_\_ 19 \_\_\_\_\_

*Compensation Commissioner.*

**Form W CI 14**

NOTICE OF AN OCCUPATIONAL DISEASE AND CLAIM FOR COMPENSATION

**W.CI 14**

Claim No. \_\_\_\_\_

**NOTICE OF AN OCCUPATIONAL DISEASE AND CLAIM FOR COMPENSATION**

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

(Previously Workmen's Compensation Act, 1941)

**[Section 4 (2) (e) and section 68 (1)-Annexure 18]**

**1. EMPLOYEE**

Surname \_\_\_\_\_ (Capital letters)  
First names \_\_\_\_\_ (Capital letters)  
Id. No. \_\_\_\_\_ Personnel No. \_\_\_\_\_  
Residential address \_\_\_\_\_  
Occupation \_\_\_\_\_ Date of birth \_\_\_\_\_ Sex \_\_\_\_\_ Marital status \_\_\_\_\_  
Postal Code \_\_\_\_\_  

	Male	Female	Married	Not married
--	------	--------	---------	-------------

**2. EMPLOYER**

Name of employer in who's service the accident was contracted

Address

Name of present or last employer

**3. NATURE OF DUTIES PERFORMED**

Describe the manner in which the employee allegedly contracted the disease (mention the causative agents or process)

4. (i) Date on which the disease was reported to the employer  
(ii) Date of first consultation with a doctor  
(iii) Name and address of doctor  
(iv) Date on which the disease was diagnosed

**5. THE EMPLOYEE'S EARNINGS AT TIME OF DIAGNOSIS OF THE DISEASE OR WHEN LAST EMPLOYED**

	Per week R	Per month R
Gross cash earnings (including average overtime and/or commission of a regular nature) Allowance of a regular nature: (a) Bonuses (e.g. 13th cheque) (b) Other (specify)		

Cash value of quarters		
Cash value of food		

I certify that the information in this form is to the best of my knowledge correct.

Date

*Signature of employee or person acting  
on his/her behalf*

**Form W CI 22**

FIRST MEDICAL REPORT IN RESPECT OF AN OCCUPATIONAL DISEASE

**W CI 22**

**FIRST MEDICAL REPORT IN RESPECT OF AN OCCUPATIONAL DISEASE**

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

(Previously Workmen's Compensation Act, 1941)

**[Section 4 (2) (e)-Commissioner's rules, forms and particulars-Annexure 19]**

Name of employee  
Address  
Name of employer  
Address

1. Date of first consultation
2. Diagnosis or nature of disease
3. Indicate the causitive substance or work-process
4. State the positive aspects from the anamnesis and/or clinical examination supporting the diagnosis (reports of all special investigations must be submitted)

5. Is the employee unfit to work?
6. Does the employee suffer from any other disease?  
If so, please specify

I certify that I have by examination of the employee satisfied myself of above-mentioned facts.

Date

*Medical practitioner*

- . All questions must be answered in full.
- . Full motivation of diagnosis will prevent unnecessary correspondence and delays in adjudication of the claim.
- . The form must be forwarded to the employer of the patient within 14 days after the first consultation.

**Form W CI 26**

PROGRESS/FINAL MEDICAL REPORT IN RESPECT OF AN OCCUPATIONAL DISEASE

**W CI 26**

**PROGRESS/FINAL MEDICAL REPORT IN RESPECT  
OF AN OCCUPATIONAL DISEASE**

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

(Previously Workmen's Compensation Act, 1941)

**[Section 74 (2)-Commissioner's rules, forms and particulars-Annexure 20]**

Claim No.

Surname of employee

(Block letters)

Christian names  
Address  
Name of employer  
Address  
Date of diagnosis

1. From what date has the employee been fit for his/her work?

**or**

Since what date has the employee been fit for work in the open labour market?

2. (a) Was the employee required to change his/her occupation following medical advice?  
(b) If so, please give the reasons
3. (a) Has there been any permanent loss of function which resulted from the occupational disease?  
(b) If so, give a detailed description thereof substantiated by special examinations where necessary
4. Has the employee's condition become stabilised?  
If so, describe in detail any permanent anatomical defect and/or impairment of functions of the occupational disease

**\*\*Account in respect of first consultation and or procedure(s)**

Your Account No.:

PR No.:

I certify that I have by examination, satisfied myself that the injury(ies)/condition of the employee is the result of the accident as described above.

Description of service	Place and dates of treatment or visits	Item of Tariff	R	c

I certify that I have by examination, satisfied myself that the injury(ies)/condition of the employee is the result of the occupational disease as described above.

Date (important)

*Signature of medical practitioner/chiropractor*

Name (printed):  
Registered address:

**N.B.:** Progress reports must be submitted on a monthly basis to the Compensation Commissioner or mutual association or employer individually, liably as the case may be until the employee's condition has become stabilised when a final medical report should be submitted.