



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

EMPLOYER'S REPORT OF ACCIDENT

The issue of this form is not an admission of any liability

(For official use only)	
Claim No.
Office
Date

DIRECTIONS FOR COMPLETION 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 results.
- 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.

(IN CASES WHERE THE ACCIDENT HAS CAUSED DEATH OR IS LIKELY TO CAUSE DEATH, UNCONSCIOUSNESS OR AMPUTATION OR CASES 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 EMPLOYER'S REPORT in full and SUBMIT WITHIN 7 DAYS without delay.

Step 2 Sign and date from where indicated.

Step 3 Hand "Part B" to the injured employee before he/she goes for initial medical treatment and instruct him/her to hand "Part B" to the medical practitioner or hospital concerned. In serious cases "Part B" must be forwarded to the medical practitioner or hospital without delay.

Step 4 Forward completed PART A together with a First Medical Report (if available) to:

THAT REGIONAL OFFICE OF THE FEDERATED EMPLOYERS MUTUAL ASSURANCE COMPANY (RF) (PTY) LTD (FEM) WITH WHOM YOU HAVE INSURED YOUR LIABILITY IN TERMS OF THE COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993.

See Reverse Part B Page 1 for addresses.

N.B.

- 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 of gaining knowledge of such accident 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 any accidents that have caused death or are likely to cause 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 Regional Director of Manpower 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.
- 6) If an injured employee should leave your employ, please keep a record of the address where he/she can be reached so that monies which might be payable to him/her by FEM, can be sent to him/her with your assistance.
- 7) Minor injuries where no medical attention was required should not be reported, however a record should be kept of such injuries.
- 8) FEM is obliged to report any injured employees who are not in possession of a valid work permit to the Department Of Labour.

NOTES FOR EMPLOYERS INFORMATION AND GUIDANCE

1. HOLIDAY FUND AND HOLIDAY BONUS CONTRIBUTIONS - CONTRIBUTIONS PAID BY EMPLOYERS IN THE BUILDING INDUSTRY TO THEIR EMPLOYEES IN RESPECT OF HOLIDAY FUNDS AND HOLIDAY BONUS, IRRESPECTIVE OF WHETHER SUCH CONTRIBUTIONS ARE PAID WEEKLY OR MONTHLY IN CASH OR PLACED TO THE CREDIT OF AN EMPLOYEE BY MEANS OF HOLIDAY STAMPS ARE REGARDED AS EARNINGS FOR THE PURPOSES OF THE ACT AND MUST BE REFLECTED IN QUESTION 46 "PART A" PAGE 2.
2. ALLOWANCES - OVERTIME PAYMENTS OR OTHER SPECIAL REMUNERATION OF CONSTANT NATURE OR FOR WORK HABITUALLY PERFORMED MUST BE DECLARED IN QUESTION 46 "PART A" PAGE 2.

Employer Date of accident

Employee Employee's I.D. No.

FURTHER PARTICULARS OF EMPLOYEE

46. Earnings of employee at the time of the accident:

	R / Week	R / Fortnight	R / Month
Basic wage			
Commission of a constant nature			
Overtime of a constant nature			
Allowances of a recurrent nature: a) Bonuses (i.e. 13th cheque)			
b) Other (specify nature)			
Cash value of: a) Free food			
b) Free quarters			
Holiday fund <input type="checkbox"/> Cash <input type="checkbox"/> Stamp			
Other payments (specify nature)			

47. **In terms of section 47 (3) of the Act, the employer is liable for the payment of compensation (i.e. 75% of the wages) for the first three months from the date of accident or until the employee resumes work (refundable by FEM)**

a) If you have already paid cash to the employee, state the amount R

b) For what period were such payments made? From...../...../..... To...../...../.....
DD MM YYYY DD MM YYYY

48. Number of days per week worked by the employee

49. Date on which the employee ceased work due to the accident 50. Time

DD MM YYYY

51. Did the employee complete his shift on the day of the accident? Yes No

52. Date on which the employee resumed work 53. Time

DD MM YYYY

(If the employee has not yet resumed work, a Resumption Report must be submitted as soon as he/she resumes duty).

54. **Next of Kin, family or friends contact details**

a) Name.....

b) Address.....

c) Telephone number.....

FURTHER PARTICULARS

55. Should the employee, to your knowledge have any physical defect, suffer from any serious disease prior to the accident or previously have received compensation for permanent disablement, give full particulars

56. Was first aid given in this case?..... Yes No

57. If a medical practitioner treated the employee, state the name of the practitioner

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

59. 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 health and safety of employees and the prevention of accidents?..... Yes No

(c) Action while under the influence of liquor or drugs?..... Yes No

NB: (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).

60. Name, address and contact number of anybody:

a) Who witnessed the accident?.....

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

61. Total number of employees injured in the same accident?.....

62. If the accident was investigated by the S.A. Police, state the name of the police station and case number

63. If motor vehicles were involved, furnish registration number(s)

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The Federated Employers Mutual Assurance Company (RF) (Pty) Ltd

Instructions:

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

(For official use only)	
Claim No.
Office
Date

EMPLOYER

1. Name of company registered with THE FEDERATED EMPLOYERS' MUTUAL ASSURANCE COMPANY (RF) (PTY) LTD (FEM)
.....

2. FEM Policy number WCC Reference number - if known

3. Contact person

4. Street address 5. Postal code

6. Postal address 7. Postal code

8. Tel. No. (.....) 9. Fax No. (.....) 10. E-mail address

11. Situation of business/site

12. Nature of business, trade or industry

EMPLOYEE (CERTIFIED COPY OF IDENTITY DOCUMENT TO BE ATTACHED)

13. a) Is the injured employee a working director working member of a CC owner of partner in the business ? Not applicable

b) Is the employee in your direct employ or that of a subcontractor ?..... Directly employed Subcontractor

14. Surname 15. First names

16. I.D. / Passport No. 17. Date of birth DD / MM / YYYY 18. Sex Male Female

19. Citizen of Work permit No.
(If not a citizen of South Africa, please attach a copy of the employee's work permit)

20. Personnel / Staff No. 21. Occupation 22. Marital State Married Single

23. Street address 24. Postal code

25. Postal address 26. Postal code

27. Tel. No. (.....) 28. Fax No. (.....) 29. CELL. NO.

30. Period in your employ (years / months)/..... 31. Expected period of disablement (days) 0-13 days 14 & more

ACCIDENT

32. Date of accident/...../..... 33. Time of accident

34. Place of accident (Site)

35. District 36. Province

37. Date on which the employee reported the accident DD / MM / YYYY 38. Time reported

39. What task was the employee performing at the time of the accident ?.....

40. Period of experience in task performed (years / months)/.....

41. Was his/her 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)

42. Short description of how the accident occurred (ALSO give a full description and mark the applicable items on Part A Page 3)
(Refer to the machine / process involved and whether the injured employee fell or was struck and all the factors contributing to the accident)
.....
.....

43. Was the accident a traffic accident on a public road ?..... Yes No

44. Nature of injury sustained. (e.g. index finger of right hand crushed)

Mark any of the following if applicable Fatal Amputation Unconsciousness

45. Are you satisfied that the employee was injured in the manner alleged by him (If not, give reasons) ?..... Yes No
(If "no" state reasons on reverse side Part A Page 3)

DECLARATION BY EMPLOYER OR AUTHORISED PERSON

I hereby declare that the particulars, shown in items 1 to 67 of this report, of an alleged injury on duty are to the best of my knowledge and belief true and accurate.

➔ Signature

Name and position

Signed on this day of in the year

Please complete in detail to ensure early finalisation.

PART A PAGE 2 MUST ALSO BE COMPLETED, PLEASE.

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The Federated Employers Mutual Assurance Company (RF) (Pty) Ltd

Instructions:

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

(For official use only)	
Claim No.
Office
Date

EMPLOYER

1. Name of company registered with THE FEDERATED EMPLOYERS MUTUAL ASSURANCE COMPANY (RF) (PTY) LTD (FEM)
.....

2. FEM Policy number WCC Reference number - if known

3. Contact person

4. Street address 5. Postal code

6. Postal address 7. Postal code

8. Tel. No. (.....) 9. Fax No. (.....) 10. E-mail address

11. Situation of business/site

12. Nature of business, trade or industry

EMPLOYEE (CERTIFIED COPY OF IDENTITY DOCUMENT TO BE ATTACHED)

13. a) Is the injured employee a working director working member of a CC owner of partner in the business ? Not applicable

b) Is the employee in your direct employ or that of a subcontractor ?..... Directly employed Subcontractor

14. Surname 15. First names

16. I.D. / Passport No. 17. Date of birth/...../..... 18. Sex Male Female

19. Citizen of Work permit No.
(If not a citizen of South Africa, please attach a copy of the employee's work permit)

20. Personnel / Staff No. 21. Occupation 22. Marital State Married Single

23. Street address 24. Postal code

25. Postal address 26. Postal code

27. Tel. No. (.....) 28. Fax No. (.....) 29. CELL. NO.

30. Period in your employ (years / months)/..... 31. Expected period of disablement (days) 0-13 days 14 & more

ACCIDENT

32. Date of accident/...../..... 33. Time of accident

34. Place of accident (Site)

35. District 36. Province

37. Date on which the employee reported the accident/...../..... 38. Time reported

39. What task was the employee performing at the time of the accident ?.....

40. Period of experience in task performed (years / months)/.....

41. Was his/her 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)

42. Short description of how the accident occurred (ALSO give a full description and mark the applicable items on Part A Page 3)
(Refer to the machine / process involved and whether the injured employee fell or was struck and all the factors contributing to the accident)
.....
.....

43. Was the accident a traffic accident on a public road ?..... Yes No

44. Nature of injury sustained. (e.g. index finger of right hand crushed)

Mark any of the following if applicable Fatal Amputation Unconsciousness

45. Are you satisfied that the employee was injured in the manner alleged by him (If not, give reasons) ?..... Yes No
(If "no" state reasons on reverse side Part A Page 3)

DECLARATION BY EMPLOYER OR AUTHORISED PERSON

I hereby declare that the particulars, shown in items 1 to 67 of this report, of an alleged injury on duty are to the best of my knowledge and belief true and accurate.

➔ Signature

Name and position

Signed on this day of in the year

DIRECTIONS TO MEDICAL PRACTITIONER / HOSPITAL 1

- 1 Note that if liability is not accepted by The Federated Employers Mutual Assurance Company (RF) (Pty) Ltd, medical expenses cannot be paid.
- 2 The first medical report 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 I.D. number as shown on this form, appear thereon. The original must be forwarded to that regional office of The Federated Employers Mutual Assurance Company (RF) (Pty) Ltd with which the employer has insured his Compensation for Occupational Injuries and Diseases Act liability as soon as possible whilst the duplicate must be kept by the medical practitioner or hospital together with this form.

REGIONAL OFFICES OF THE FEDERATED EMPLOYERS MUTUAL ASSURANCE COMPANY (RF) (PTY) LTD**HEAD OFFICE**

Postal address Private Bag 87109, Houghton, 2041
Physical address 114 Oxford Rd, Houghton Estate, Johannesburg, 2198
Telephone number (011) 359-4300
Facsimile number (011) 359-4302

Johannesburg

Branch Manager A. Reddy
Postal address Private Bag 87109, Houghton, 2041
Physical address 114 Oxford Rd, Houghton Estate, Johannesburg, 2198
Telephone number (011) 359-4399
Facsimile number (011) 359-4336

Cape Town

Branch Manager B. Mangisa
Postal address P.O. Box 2555, Cape Town, 8000
Physical address 8th Floor, 80 Strand Street, Cape Town, 8001
Telephone number (021) 443-2200
Facsimile number (021) 425-1544

Durban

Branch Manager S. Munnoo
Postal address P.O. Box 1157, Umhlanga Rocks, 4320
Physical address 1st Floor RewardCo Building, 2 Ncondo Place, Umhlanga Ridge, 4320
Telephone number (031) 277-0660
Facsimile number (031) 202-9750

WWW.FEMA.CO.ZA

THE DEPARTMENT OF LABOUR CONTACT DETAILS

Call Center 086 010 5350
 Fax (012) 323-8627
 (012) 325-6686
 (012) 326-7889
 (012) 323-6986

e-mail cf-info@labour.gov.za
 Website http://www.labour.gov.za

THE COMPENSATION COMMISSIONER
 COMPENSATION HOUSE
 CNR. SOUTPANSBERG AND HAMILTON ROAD
 P.O. BOX 955
 PRETORIA
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