The Federated Employers' Mutual Assurance Company Limited

(Reg. No. 1936/008971/06)

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 form 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 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 posession 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 [Cash] [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....../....../...... (DD MM YYYY) To....../....../...... (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 ....../....../...... (DD MM YYYY) 50. Time ....

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

52. Date on which the employee resumed work ....../....../...... (DD MM YYYY) 53. Time ....

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

54. Dependant of employee 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) ....

SAFETY QUESTIONNAIRE AND ANY ADDITIONAL DETAILS MUST BE SUPPLIED ON PART A PAGE 3

EMPLOYER'S REPORT OF ACCIDENT

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

The Federated Employers' Mutual Assurance Company Limited

(For official use only)
Claim No. ....
Office ....
Date ....

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

EMPLOYER

1. **Name of company registered with THE FEDERATED EMPLOYERS' MUTUAL ASSURANCE COMPANY LIMITED (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.

Name and position ....

Signed on this .... **day of** .... **in the year** .... → **Signature** ....

Please complete in detail to ensure early finalisation.

PART A PAGE 2 MUST ALSO BE COMPLETED, PLEASE.

Employer .... **Date of accident** ....

Employee .... **Employee's I.D. No.** ....

42. Continuation of point 42 of the previous page. Contributing factors/causes applicable. (Mark the applicable item/s at A and B)

A)

Defective Plant	
Defective machine	
Unfavorable conditions at work	
Fault of employer	
Fault of injured employee	
Fault of supervisor	

B)

Railway		Explosions	
Building work		Rotating machine	
Electricity		Press/Rollers	
Chemicals		Woodworking machine	
Poisoning		Lifting machine	
Burns		Hand tool	

Other machinery (Specify) ....

Any other contributing factors, not mentioned above (Specify) ....

....

....

SAFETY QUESTIONNAIRE

64. Did the employee receive induction training ?.. Yes | No

65. Was the employee wearing the required safety equipment at the time of the accident ?.. Yes | No

66. Was the employee supplied with safety equipment ?....................................

Hard hat	Masks	Earplugs	Harness
Goggles	Footwear	Gloves	Other

If "Other", specify ....

67. If this was a motor vehicle accident:
   a) When was the vehicle last serviced ?..
   b) When were the tyres last changed ?..
   c) Was the vehicle roadworthy ?.. Yes | No
   d) Carrying capacity of the vehicle i) Tare .... ii) No. Persons ....
   e) Was the employee licensed to drive this type of vehicle ?.................................... Yes | No

ADDITIONAL DETAILS OR COMMENTS

The rest of this page must be used for any additional details or comments regarding the accident.

....

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The Federated Employers' Mutual Assurance Company Limited

(For official use only)	
Claim No.	....
Office	....
Date	....

Instructions:

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

EMPLOYER

1. **Name of company registered with THE FEDERATED EMPLOYERS' MUTUAL ASSURANCE COMPANY LIMITED (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)** ....

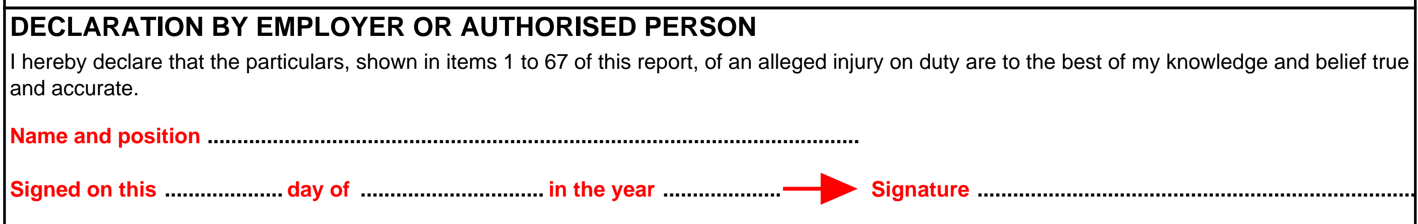
Mark any of the following if applicable ....

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.

Name and position ....

Signed on this .... **day of** .... **in the year** .... **Signature** ....

DIRECTIONS TO MEDICAL PRACTITIONER / HOSPITAL

1 Note that if liability is not accepted by the Compensation Commissioner medical expenses cannot be paid by The Federated Employers' Mutual Assurance Company Limited.

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 Limited 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 LIMITED

HEAD OFFICE

Postal address PRIVATE BAG 87109, HOUGHTON, 2041
Physical address BUILDING 2, 1ST FLOOR, 101 CENTRAL STREET, HOUGHTON
Telephone number (011) 359-4300
Facsimile number (011) 359-4302

JOHANNESBURG

Branch Manager R G. SPREADBURY
Postal address PRIVATE BAG 87109, HOUGHTON, 2041
Physical address BUILDING 2, GROUND FLOOR, 101 CENTRAL STREET, HOUGHTON
Telephone number (011) 359-4300
Facsimile number (011) 359-4336

CAPE

Branch Manager R. SAUNDERS
Postal address P O BOX 2555, CAPE TOWN, 8000
Physical address 8TH FLOOR, 80 STRAND STREET, CAPE TOWN
Telephone number (021) 418-3210
Facsimile number (021) 425-1544

NATAL

Branch Manager M. VERNON
Postal address P O BOX 50045, MUSGRAVE ROAD, 4062
Physical address SUITE 901, 9TH FLOOR MUSGRAVE TOWERS, 115 MUSGRAVE ROAD, BEREA
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
0001