



BUILDING 2, 1ST FLOOR
101 CENTRAL STREET
HOUGHTON
2041

PRIVATE BAG 87109
HOUGHTON
2041

Tel (011) 359-4300

RESUMPTION REPORT

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

This form must be completed and submitted by the employer **immediately** once the employee resumes work or if discharged by yourself immediately thereafter.

Claim Number _____	Date of Accident _____	Staff number _____
Employer _____		
Employee _____		

1.	Date ceased work	Date _____
2.	When did the employee resume work permanently?	Date _____
3.	Did he resume work for any period subsequent to the accident but prior to the date of resumption given in Item 2? If so, give dates, rate of earnings and explain circumstances.	From Date
		To Date

4.	Further information or remarks.	
5.	The employee left my service on _____ (date)	
6.	The employee's present address is _____ _____ _____	

I hereby declare that the particulars furnished in the foregoing report are true and correct.

SIGNATURE OF EMPLOYER _____ **DATE** _____

FEDERATED EMPLOYERS' MUTUAL ASSURANCE CO LTD
1936/008971/06

Directors

J.A. BARROW (Chairman), D.G.BARROW,R.G.HURRY, A.P.H. JAMMINE, D.H. MITCHELL, H. NGAKANE, H. WALKER, P.L. WILMOT

Managing director
C.E. SAVILLE