OCCUPATIONAL HEALTH AND SAFETY (AMENDMENT) ACT 1989

FIRST SCHEDULE

Section 32 (2)

DETAILS REQUIRED OF ACCIDENT OR ILLNESS AT WORK

NAME OF EMPLOYER: _____

EMPLOYER REGISTRATION NO. | | | | | | | | | | | |

ADDRESS OF EMPLOYER: _____

NAME OF INJURED EMPLOYEE: _____

IDENTITY NO OF EMPLOYEE: | | | | | | | | | | | |

DATE OF BIRTH OF EMPLOYEE: _____

ADDRESS OF INJURED EMPLOYEE: _____

OCCUPATION OF INJURED EMPLOYEE: _____

DATE OF ACCIDENT: _____

TIME OF ACCIDENT: _____

Description of accident: e.g fall from building under construction (giving height) fingers caught in … etc _____

_____

_____

Machine involved if any: _____

_____

Make type and purpose e.g Robinson combined woodworking machine: _____

_____

Nature of injury: e.g Tip of forefinger of left hand severed, broken arm, etc

_____

Monthly earnings at the date of the accident SR _____

Nature and type of work being done at time of accident

_____

_____

Estimated length of absence: _____

If fatal, the official cause of death e.g fractured skull, internal injuries, shock, etc

_____

_____

_____

DATE: ……

_____

SIGNATURE OF EMPLOYER

NOTE: A copy of this form (as sent to the Director