labour

Department:
Labour
REPUBLIC OF SOUTH AFRICA

Claim Number: .....

NOTICE OF AN OCCUPATIONAL DISEASE AND CLAIM FOR COMPENSATION

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 (ACT NO. 130 OF 1993)
[Section 68(1) – Commissioner's rules, forms and particulars – Annexure 18]

This form must be completed by or on behalf of the injured employee/dependants and sent to the Compensation Commissioner, P O Box 955, Pretoria, 0001.

(BLOCK LETTERS)

1. EMPLOYEE:

Surname .....

First Names .....

Identity Number ..... Personnel Number .....

Residential address .....

..... Postal Code .....

Postal address .....

Date of birth ..... Sex ..... Married or Single .....

Occupation .....

Contact details .....

2. EMPLOYER:

Name of employer in who's service the disease 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) .....

Please complete the reverse side

4. (i) Date on which the disease was reported to the employer .....

(ii) Date of first consultation with a doctor .....

(ii) 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.

.....
Signature of employer or person acting on his/her behalf.

Date: .....