labour

Department:
Labour
REPUBLIC OF SOUTH AFRICA

EMPLOYER'S REPORT OF AN OCCUPATIONAL DISEASE

For office use only

Claim No. .....

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993
(ACT No. 130 OF 1993)
[Section 68(2) – Commissioner's rules, forms and particulars – Annexure 12]

This report must be completed in respect of an alleged occupational disease which an employee when he reports it alleges that the disease arisen out of and in the course of his employment irrespective of the fact that he may have contracted the disease in the employment of a previous employer.

N.B.: It is common knowledge that he symptoms of some diseases only appears years later after an employee might have left the employer's service where he was exposed.

It is therefore important to note that where a disease has been contracted in the employ of a previous employer, the cost of the claim, if it is accepted, shall not be set off against the employer in who's employ the disease was diagnosed.

This report must be forwarded to the:

Compensation Commissioner

P.O. Box 955

Pretoria

0001

1. A separate form must be completed for each employee.
2. This report should not be held back until the medical reports have been obtained.
3. An employer who fails to report an occupational disease on this form within 14 days to the Compensation Commissioner is in terms of this Act guilty of an offence and may be held liable for the full cost of the claim.
4. Please use the **W.CL.2(E)** form for the reporting of an **accident.**
5. Please keep record of an employee's address if he has contracted an occupational disease and leaves your employment in order that compensation if any may be awarded to him.

FOR OFFICE USE

ACCEPTANCE STAMP	CONTROL
REPUDIATE	EMPLOYER'S INDEX
NAME	
DATE	

DECLARATION BY EMPLOYER OR AUTHORISED PERSON

I hereby declare that the particulars, shown in items 1 to 40 of this report, of an alleged occupationall disease contracted by the employee, are to the best of my knowledge and belief true and accurate.

Signed on this ..... day of .....20..... **Signature** .....

EMPLOYER

1. Registered name with the Compensation Commissioner .....
2. Registered number of this business with the Compensation Commissioner
3. Contact person .....
4. Street address ..... 5. Postal code .....
6. Postal address..... 7. Postal code ..... 8. Tel. no. (.....) .....

9.1 Fax no. (.....) ..... 9.2 E-mail address .....

10 E-mail addressSituation of business/farm .....

11. Nature of business, trade or industry .....

EMPLOYEE

12. Surname ..... 13. First names .....

Male	Female

14. ID no. ..... 15. Date of birth ...../...../..... 16. Sex

17. Marital state | Married | Single | 18. Citizen of .....
19. Personnel no. ..... 20. Occupation .....

21. Street address ..... 22. Postal code .....

23. Period in your employ (years/months) .....

24. Is the injured employee a working director, working member of a CC, owner of or a partner in the business? .....

OCCUPATIONAL DISEASE

25. Nature of disease .....
26. Date the disease was diagnosed .....
27 Alleged cause of disease .....

.....
(State the agent present in the work-place and with which he had contact that caused the disease)

28. For how long a period was he exposed .....
29. Date employee reported the disease .....
30. Please mention th ename and address of the employer if the employee did not contract the disease in your employment

.....

.....

.....

.....

31. What type of work was the employee performing with the other employer .....

OTHER PARTICULARS OF EMPLOYEE

32. Earnings of employee at the time of the diagnosis of the disease

	R/Week	R/Month
Gross cash earnings:	.....	.....
(Including average payments for overtime and/or commission of a constant character)		
Allowances of a recurrent nature:		
a) Bonuses (i.e. 13th cheque)	.....	.....
b) Other allowances (specify nature)	.....	.....
Cash value of food	.....	.....
Cash value of free quarters.....	.....	.....

33. Will the employee during temporary total disablement continue to receive from you:

Free Food? YES NO

Free quarters? YES NO

34. Are you prepared to make cash payments during temporary disablement that lastss longer than three months?

YES NO

35. If you have already paid cash to the employee, state the total amount R.....

36. For what period where such payments made? From ...../...../..... to ...../...../.....

37. Date on which the employee ceased work .....

38. Date on which the employee resumed work .....
[If employee has not yet resumed work, a Resumption Report (W.Cl. 6) must be submitted as soon as he resumes duty.]

FURTHER PARTICULARS

39. If the employee did to your knowledge receive compensation previously for the same disease or another disease or in respect of an accident, give particulars .....

.....

40. Was the disease caused by the employee's –

(a) Deliberate non compliance of directions YES NO

(a) Deliberate disregard of the terms of any law or statutory regulation designed to ensure the safety or health of employees or the prevention of diseases YES NO

(N.B.: If any reply is in affirmative, the employee must furnish an explanatory statement which must then be attached hereto together with your comments thereon.)

[SEE REVERSE SIDE]

Diseases	Work
	(a) Any work involving the handling of or exposure to any of the following substances emanating from the workplace concerned:
Pneumoconisis-fibrosis of the parencyma of the lung	organic or inorganic fibrogenic dust
Pleural thickening causing significant impairment of function	asbestos or asbestos dust
Bronchopulmonary disease	metal carbides (hard metal)
Byssinosis	flax, cotton or sisal
Occupational asthma	the sensitising agents – (1) isocyanates (2) platinium, nickel, cobalt, vanadium or chromium salts (3) hardening agents, including epoxy resins (4) acrylic acids or derived acrylates (5) soldering or welding fumes (6) substances from animals or insects (7) fungi or spores (8) proteolytic enzymes (9) organic dust (10) vapours or fumes of formaldehyde, anhydrides, amines or diamines
Extrinsic allergic alveolitis	moulds, fungal spores or any other allergenic proteinaceious material, 2,4 toluene-di-isocyanates
Any disease or pathological manifestations	beryllium, cadmium, phosphorus, chromium, manganese, arsenic, mercury, lead, fluorine, carbondisulfide, cyanide, halogen derivates of aliphatic or aromatic hydrocarbons, benzene or its homologues, nitro-glycerine or other nitric acid esters, hydrocarbons, trinitrotoluol, alcohols, glycols or ketones, acrylamide, or any compounds of the aforementioned substances
Erosion of the tissues of the oral cavity or nasal cavity	irritants, alkalis, acids or fumes thereof
Dysbarism, including decompression sickness, barotrauma or osteonecrosis	abnormal atmospheric or water pressure
Any disease	ionising radiation from any source
Allergic or irritant contact dermatitis	dust, liquids or other external agents or factors
Mesothelioma of the pleura or peritoneum or other malignancy of the lung	asbestos or asbestos dust
Malignancy of the lung, skin, larynx, mouth cavity or bladder	coal-tar, pitch, asphalt or bitumes or volatiles thereof
Malignancy of the lung, mucous membrane or the nose or associated air sinuses	nickel or its compounds
Malignancy of the lung	hexavalant chronium compounds, or bis chloromethyl ether
Angiosarcoma of the liver	vinyl chloride monomer
Malignancy of the bladder	4-amino-diphenyl, benzidine, beta, naphtylamine, 4-nitro-diphenyl
Leukaemia	benzene
Tuberculosis of the lung	(1) crystalline silica (alpha quartz) (2) mycobacterium tuberculosis or MOTTS (mycobacterium other than tuberculosis) transmitted to an employee during the performance of health care work from a patient suffering from active open tuberculosis
Brucellosis	brucella abortus, suis or melliitensis transmitted through contact with infected animals or their products
Anthrax	bacillus anthracis transmitted through contact with infected animals or their products
Q-fever	coxiella burneti emanating from infected animals or their products
Bovine tuberculosis	mycobacterium bovis transmitted through contact with infected animals or their products
	(b) Any work involving the handling of or exposure to any of the following:
Hearing impairment	excessive noise
Hand-arm vibration syndrome (Raynaud's phenomenon)	vibrating equipment
Any disease due to overstraining of muscular tendonous insertions	repetitive movements

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: .....

labour

Department:
Labour
REPUBLIC OF SOUTH AFRICA

FIRST MEDICAL REPORT IN RESPECT OF AN OCCUPATIONAL DISEASE

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

[Section 74(1) – Commissioner's rules, forms and particulars – Annexure 19]

Claim Number: .....

Name and Surname of employee: .....

Identity Number: .....

Address .....

Name of employer.....

Address .....

1. Date of first consultation .....
2. Diagnosis or nature of disease .....
3. Indicate the causative substance or work-process .....
4. State the positive aspects from the anamnesis and/or clinical examination supporting the diagnosis (reports of all special investigations must be submitted).

   .....

   .....

   .....

   .....
5. Is the employee unfit to work?.....
6. Does the employee suffer from any other disease?.....
   If so, please specify .....

Account in respect of consultation and/or procedure(s)

Your Account No. ..... PR No. .....

Description of service	Place and dates of treatment or visits	Item of Tariff	R	c

I certify that I have by examination of the employee satisfied myself of above-mentioned facts.

Date (important) ....

Medical practitioner

Name printed: .....

Registered address: .....

: .....

- All questions must be answered in full.
- Full motivation of diagnosis will prevent unnecessary correspondence and delays in adjudication of the claim
- The form must be forwarded to the employer of the patient within 14 days after the first consultation.

labour

Department:
Labour
REPUBLIC OF SOUTH AFRICA

EXPOSURE HISTORY

Claim Number: .....

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993
[Section 68(2) – Commissioner's rules, forms and particulars – Annexure 12]

Additional information required in all cases of occupational diseases. Where applicable.

NAME AND SURNAME OF EMPLOYEE .....

IDENTITY NUMBER .....

1. PLEASE STATE THE PERIOD (S) THE EMPLOEE WORKED **IN ENVIRONMENTS WITH EXPOSURES RELATED** TO HIS/HER DISEASE. *(Start with the most recent employer)*

EMPLOYER	PERIOD		OCCUPATION	EXPOSURE
	From:	**To:**		

2. DESCRIPTION OF EXPOSURE EMANATING FROM THE WORKPLACE CONCERNED

2.1 Describe the types of occupations the work methods used and the materials to which the employee may have been exposed.

Examples of occupations: - Mason in a blast furnace; grinding of sandstone: stone mason; monumental mason; welding; boiler making; metal casting; boiler or pipe insulation; quarry work; use of abrasive powders; tunneling; mine working (surface or underground).

.....

.....

.....

.....

2.2 Year of first exposure

2.3 The duration / years of exposure (which may not be the same as years in an occupation)

.....

2.4 The frequency of exposure (once per week for an hour or 8 hours every day)

.....

.....

.....

2.5 Provide any objective measurements of exposure where applicable (supply details if possible (e.g. material safety data sheets, risk assessments or results of environmental hygiene assessments)

.....

.....

.....

3. SMOKING HISTORY

.....

.....

.....

4. NON OCCUPATIONAL ENVIRONMENTAL OR LEISURE TIME EXPOSURES

.....

.....

.....

5. ANY RELEVANT ADDITIONAL INFORMATION

.....

.....

.....

.....

REPORTING OFFICER .....

DATE .....

ADDRESS .....

.....

.....

.....

Telephone numbers .....

labour

Department:
Labour
REPUBLIC OF SOUTH AFRICA

Claim Number: .....

PROGRESS/FINAL MEDICAL REPORT IN RESPECT OF AN OCCUPATIONAL DISEASE

(*Delete which is not applicable)

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

[Section 74(2) – Commissioner's rules, forms and particulars – Annexure 20]

Surname of Employee .....
(Block letters)

Full Names .....

ID Number .....

Address .....

Name of employer .....

Date of diagnosis .....

---

1. From what date has the employee been fit for his/her work?

   .....

   or

   Since what date has the employee been fit for work in the open labour market? .....

   .....

2. (a) Was the employee required to change his/her occupation following medical advice? .....

   .....

   (b) If so, please give the reason .....

   .....

3. (a) Has there been any permanent loss of function which resulted from the occupational disease? .....

   .....

   (b) If so, give a detailed description thereof of substantiated by special examinations where necessary .....

   .....

4. Has the employee's condition become stabilised? .....

   If so, describe in detail any permanent anatomical defect and/or impairment of functions of the occupational disease .....

   .....

   .....

   .....

   .....

   .....

Account in respect of consultation and/or procedure(s)

Your Account No. ..... PR No. .....

Description of service	Place and dates of treatment or visits	Item of Tariff	R	c

I certify that I have by examination, satisfied myself that the condition of the employee is the result of the occupational disease as described above.

Date (important) ....

Signature of medical practitioner/chiropractor

Name printed:

.....

Registered address: .....

: .....

: .....

N.B.: Progress reports must be submitted on a monthly basis to the Compensation Commissioner or mutual association or employer individually liability as the case may be until the employee's condition has become stabilised when a final medical report should be submitted.