

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.

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ADDRESS OF EMPLOYER: _____

NAME OF INJURED EMPLOYEE: _____

IDENTITY NO OF EMPLOYEE:

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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