FORM 6

WORKERS' COMPENSATION FUND CONTROL BOARD
P.O BOX 71534 NDOLA
Email: compensation@workers.com.zm Phone: 02-610481/8 / Fax: 02-610487

FOR OFFICIAL USE : CLAIM NUMBER

EMPLOYER'S REPORT OF AN ACCIDENT TO A WORKER

(Section 88 of Act No. 10 of 1999)

To be addressed to: THE WORKERS' COMPENSATION COMMISSIONER,
P O BOX 71534, NDOLA OR NEAREST BRANCH OFFICE

1. EMPLOYER (BLOCK CAPITALS)

Name under which trade or business is carried on……

Address……

Nature of Business, trade or industry ……

Telephone No. …… Email address: ……

2. WORKER (BLOCK CAPITALS)

Full Name …… **SEX**: Male/ Female NRC ……

Occupation: …… Date of Birth: ……

Village …… Chief …… District ……

Residential Address……

Email Address ……Tel/Cell ……

Marital Status: …… Name of Spouse: …… Spouse Date of Birth: ……

Is worker right or left handed: ……

3. CHILDREN

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
(i) ……		(v) ……	
(ii) ……		(vi) ……	
(iii) ……		(vii) ……	
(iv) ……		(viii) ……	

4. EMPLOYMENT RECORD

(a) For how long has he been your worker? ……
(b) If not your direct employee, give the name and address of the Sub-Contractor……
……
……
(c) Prior to this accident had he/she, to your knowledge any physical defect or did he suffer from any serious disease? ……

If yes give details……

5. EARNINGS

(a) Basic Wages (excluding bonus, commission or allowances)

Per Hour or Per Shift	or Per Week	or Per Ticket	or Per Month	

(b) Normal working hours per week …… or per shift
……

6. PREVIOUS ACCIDENT RECORD

(a) Has he/she previously received compensation for permanent disablement?……

(b) If yes, when and by who was he/she employed? ……..……..……

……..……..

……..

7. CURRENT ACCIDENT

(a) Where did it occur? (State site, e.g.workshop, underground,etc) ……..……..

(b) When did it occur? Date……..…… Time……..……..

© When did the worker report it? Date…… Time…….…….....

(d) If he/she failed to report it on the same day, what is the explanation ……..……

……...

(e) Describe how the accident happened.

……

.....

.....

(f) Did it result from action properly within the scope of the worker's duties? ……If not, please attach explanatory statement.

Note: *RTA, Assault, Murder etc should be accompanied by a Police report*

8. CAUSE OF ACCIDENT

(i) Was Accident caused by: (a) Deliberate violation of rules/ regulations? ……..…… (b) Drunkenness? ……..……..

© Deliberate contravention of any law made for the purpose of ensuring the safety of workers?……..……

(**IMPORTANT:** If reply is in affirmative, please attach explanatory statement)

(ii) Witnesses to the accident: Names: ……

Address……..……Tel/Cell……

(iii) Was the accident caused by the action of a person other than the worker? …… If yes, give the following details:

Name…….. Address ……..……..……...

Email:…….. Tel/Cell ……...

9. OTHER OFFICIAL INQUIRIES

(a) Has notice been received of any magisterial or other official inquiry? ……..……..

(b) If the accident was investigated by the Police, state Name of police station: ……

10. PARTICULARS OF DISABLEMENT

(a) Describe the nature and extent of the injuries sustained, mentioning parts of the body, and in the case of limb, or eye, stating right or left side ……..……

……

……

b) When did the worker cease work as a result of the accident? Date……Time……..……

(c) State probable period worker will be off duty ……

(d) Name of Doctor attending to work ……..…… address ……

(e) If in hospital, Name of Hospital: ……

Address……..…….……

……

11. HISTORY OF SERVICE IN SCHEDULED AREAS (For employers in scheduled areas only)

DIVISION	FROM	TO	OCCUPATION	AREA OF WORK	MONTHS	DAYS
TOTAL NUMBER OF MONTHS WORKED IN SCHEDULED AREAS						

I hereby certify that to the best of my knowledge and belief, the particulars furnished in this report are true and correct.

Employer's Signature …… **Position** …… **Date** ……

OFFICIAL STAMP

FOR OFFICIAL USE ONLY (WORKERS' COMPENSATION FUND)

Received by	**Employer's Account Number**	**Premium Checked by**	**Claim Accepted/Rejected By**
…… Date: ……..	…… Date: …….	…… Date: …….	…… Date: ……