Form No. 18

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

EMPLOYER'S CLAIM FOR PERIODICAL PAYMENTS

(Section 66 of Act No. 10 of 1999)

CLAIM No. …….

This form should be completed and returned to the Workers' Compensation Commissioner or the nearest branch office as soon as the Worker resumes full duties. Prompt return of the form is requested to avoid unnecessary delay in the reimbursement of periodical payments.

1.Name of Employer.……

Address:……..……

……..……

2. Name of Worker

3. Date of Accident

4. Date on which worker returned to light duties following accident, if applicable: ……

5. Nature of work on which worker was employed during the period he/she was employed on light duties.

……..……..……

6. Did worker perform his/her normal duties during the period he/she was on light duty? **YES / NO**

7. If he/she did not perform his/her normal duties, please state the value of his/her work to you during this period in relation to the normal value of his/her work i.e. 50%, 75% etc.

8. Date on which worker resumed full duties ……

9. Total amount worker was paid from the date of the accident to the date of resumption of full duties

K ……

10. Medical Certificate covering the period the worker was absent from work:
Enclosed / not enclosed

NB: No re – imbursement of periodical payments can be made unless period for which the refund requested is covered by a medical certificate.

11. Received the amount stated above.
Worker's Signature / Thumbprint …….

Employer's Signature: …… **Position:** ……..

Date: ……...

OFFICIAL STAMP