Claim Number: .....

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993
(Previously Workmen's Compenation Act, 1941)

SWORN/CONFIRMED STATEMENT BY EMPLOYEE

Employee: _____

Employer: _____ Date of Accident: _____

1. Give a detailed description of how you were injured. _____

2. On what grounds are you of the opinion that you were injured whilst on duty? _____

3. On what date and at what time were you injured? _____

4. On what date and at what time did you notify your employer of the incident? Give the name of the person to whom you reported it. _____

5. Why did you not regard it necessary to report to your employer immediately that you were injured during working hours? _____

6. On what date and at what time did you consult a medical practitioner for the first time? Give his name and address. _____

7. Give your reasons for not having regarded it necessary to consult a doctor immediately. _____

8. On what date and at what time did you regard it necessary to cease work? _____

9. Why did you cease work? _____

10. Give the name/s and address/es of witness/es who are able to confirm what happened. _____

11. Submit a sworn statement by each witness describing in full what he knows of the incident. The statements must be attached hereto.