GP 358/81

LAB.WCA 2

SOLOMON ISLANDS GOVERNMENT
LABOUR DIVISION

P. O. Box G26
Honiara
Tel: 26811

To the Employer.....
.....
.....
.....

Date.....

Workmen's Compensation Act (Cap 78)

RETURN

For use in cases of Industrial Injury or Occupational Diseases

ACCIDENT CASE FILE NO:.....

Workmen's Name ..... Injured on (date).....
Employed by (precise name of business or individual) .....
.....
at (place of work and P. O. Box).....

1. Please supply in respect of the above named workman the particulars requested below and return completed *duplicate* copies of this form to me.

2 If, because it was a serious or permanent injury, the case requires assessment by a Medical Practitioner, enter as many particulars as possible and send the workman with *two copies of this form and by appointment* to your hospital. In cases *where there is clearly no permanent incapacity* the worker does not have to be seen by a Medical Practitioner.

(Signature).....
For: Commissioner of Labour

EMPLOYER PLEASE COMPLETE WHEREVER APPLICABLE

3 Was the workman kept on full wages? YES or NO

4 If the answer to 3 is NO; state the amount of any advance or payment made to the workman during his period of incapacity for work
.....

5 Address of hospital and any other places of Treatment.....
.

1 Date of treatment as IN patient, from..... To .....

2 Date of treatment as OUT patient, from.....to.....

3 Date of ability to resume duty.....

4 If patient has died, date of death .....

5 Nature of injury (mark in appropriate bracket).

[ ]	Contusions and Abrasions	[ ]	Fracture (Simple and/or Comp'd
[ ]	Burns and Scalds	[ ]	Sprains and Strains
[ ]	Concussion	[ ]	Asphyxiations or Drowning
[ ]	Cuts and Laceration	[[	Tearing of internal Organs
[ ]	Punctured Wounds	[ ]	Electric Shock
[ ]	Amputation	[ ]	Eyes – left/Right/Both
[ ]	Dislocations	[ ]	Other Injuries

[ ] Occupational Diseases (give details).....
.....
.....

6 Location of Injury (mark in appropriate bracket)

[ ] Head

[ ] Face

[ ] Arm at or below elbow (L or R.....)

[ ] Arm below elbow (L or R .....)

[ ] Hand (L or R .....)

[ ] Thumb (L or R .....)

[ ] Any one finger (L or R .....)

[ ] 2 fingers same hand (L or R .....)

[ ] 3 fingers same hand (L or R .....)

[ ] 4 fingers same hand (L or R .....)

[ ] Thumb and one finger same hand (L or R .....)

[ ] Thumb and two fingers same hand (L or R .....)

[ ] Thumb and 3 fingers same hand (L or R .....)

[ ] Thumb and 4 fingers same hand (L or R .....)

[ ] Leg at or above knee (L or R)

[ ] Leg below knee (L or R .....)

[ ] Foot (L or R .....)

[ ] great toe of any 2 or more toes same foot (L or R)

[ ] One eye loss of sight (L or R .....)

[ ] Two great toes

[ ] one eye Loss of sight (L or R .....)

[ ] Both eyes loss of sight (.....)

[ ] Foreign body in eye (L or R .....)

[ ] One ear loss of hearing (L or R .....)

[ ] Both ears loss of hearing

...

7 Further observations if any .....
.....

8 REPORT OF REGISTERED MEDICAL PRACTITIONER

Please indicate with a tick ( ) the type of incapacity 'A' 'B' (i) 'B' (ii)

In the case or 'B' (i) enter appropriate percentage as per First Schedule and 'B' (ii) indicate assessed percentage

'A' Permanent Total Incapacity (Section 7 (1))

'B' (i) The degree of loss of earning capacity permanently caused by the injury as specified in the First Schedule to the Act (Section 8 (1) (a) is .....

'B' (ii) The degree of loss of earning capacity permanently caused by the injury not specified in the First Schedule to the Act (Section 8 (1) (b) .....

'C' The Injured Workman is required again for interim/final assessment on (date).....

'D' I have the following comments:-
.....
.....
.....

.

Date .....

Name .....

Signature.....

Qualification .....

.....