

**WORKMEN'S COMPENSATION ACT
(Chapter 78)**

RETURN OF ACCIDENT/OCCUPATIONAL DISEASE

(Pursuant to the Workmen's Compensation (Accident and Occupational Disease Return Regulations)

The following particulars are reported of an accident/occupational disease which caused to the workman death/injury, incapacitating him from attending from a period of more than 3 days at work on which he was employed:-

1 EMPLOYER

- (i) Name
- (ii) Address
- (iii) Trade/occupation
- (iv) Name and address of insurance Company (*if insured against accident of occupational disease to workman*)
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2 WORKMAN

- (i) Name
- (ii) Sex
- (iii) Age
- (iv) Occupation
- (v) Address
- (vi) Any Identity Particular

In FATAL cases please give details of DEPENDENTS and NEXT OF KIN on the reverse of this form.

3 ACCIDENT/OCCUPATIONAL DISEASE

- (i) Date and time (of accident/Date of onset(of disease))
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- (ii) Circumstances in which accident/disease occurred (if accident due to machinery give details of part or parts causing accident)
.....
- (iii) Particulars of injury/Disease as known to the employer
.....
- (iv) Particulars of medical attention and where given
.....

4 EARNINGS

(Average per month calculated over the past twelve months or for such lesser period as the workman has been employed)

Rate of wages.....\$
 Cost of living allowances.....\$
 Other allowances or regular payments
 (e.g. bonus, overtime, etc.).....\$
 Value of food.....\$
 Value of housing.....\$
 Value of fuel.....\$

TOTAL EARNINGS PER MONTH _____

Date.....

.....
Signature of employer

TO BE SENT WITHIN SEVEN DAYS OF ACCIDENT TO:

The Commissioner of Labour,
 Labour Division, P.O. Box G26,
 Honiara, S. I.