COMMISSIONER OF LABOUR

REPORT OF INJURY OR DANGEROUS OCCURRENCE [*SEE NOTE ON

To be submitted to the Commissioner of Labour, P.O. Box 198, Mbabane

4869

* Completing and signing this form does not constitute an admission of liability of any kind, either by the person making report or any other person*

A. INFORMATION OF THE EMPLOYER

1. Company's Name: .....
2. Address: ..... 3. Tel: No.: .....
4. Nature of work: .....
5. Name of Company Insurance: ..... 6. Policy No.: .....

B. INFORMATION ON THE INJURED PERSON

7. Name: ..... 8. Age: ..... 9. Sex: .....
10. Marital Status: ..... 11. Pay No.: ..... 12. Tax No.: .....
13. Type of Employment: .....

14. Terms of employment:

Permanent		Temporary		Seasonal		Casual	

15. Home Address: .....
16. Chief's Name: ..... 17. Indvuna: .....

18. Rate of Wages:

Weekly/Monthly Earning=E		Value of Housing=E	
Average overtime bonus=E		Value of Rations=E	
Value of fuel=E		Value of other fringe benefits=E	

19. For fatal cases: A) Name of next of kin: ..... B) Relationship: .....
C) Signature: .....

C: INFORMATION OF THE ACCIDENT

20. Date of Accident: ..... 21. Time of Accident: .....
22. Part of body injured by the accident: .....
23. Nature of injury (Please look at cover page for guidance) .....
24. Section where accident happened: .....

25. Cause of accident (Tick in box or describe in "other")

Falling objects		Falling person		Moving machinery		Other:
Hand tools		Electricity		Chemicals or gasses		
Dust		Fire		Explosion		
Transport		Lifting/carrying		Sharp object		

26. Describe what happened: .....
.....
.....
.....
27. What protective measures were used: .....
28. Name of Supervisor: ..... 29. Name of first witness: .....
30. Name of second witness: .....

D: COMPANY OFFICIAL USE, NAME OF PERSON COMPLETING THE FORM:

31. Name in Block Letters: ..... 32. Date: .....
33. Signature: ..... 34. Position in company: .....