



labour

Department: Labour
REPUBLIC OF SOUTH AFRICA

Claim Number:

NOTICE OF AN OCCUPATIONAL DISEASE AND CLAIM FOR COMPENSATION

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 (ACT NO. 130 OF 1993)
[Section 68(1) – Commissioner’s rules, forms and particulars – Annexure 18]

This form must be completed by or on behalf of the injured employee/dependants and sent to the Compensation Commissioner, P O Box 955, Pretoria, 0001.

(BLOCK LETTERS)

1. EMPLOYEE:

Surname
First Names
Identity Number Personnel Number
Residential address
..... Postal Code
Postal address
Date of birth Sex Married or Single
Occupation
Contact details

2. EMPLOYER:

Name of employer in who's service the disease was contracted
Address
.....
Name of present or last employer

3. NATURE OF DUTIES PERFORMED:

Describe the manner in which the employee allegedly contracted the disease (mention the causative agents or process)

Please complete the reverse side

-
4. (i) Date on which the disease was reported to the employer
- (ii) Date of first consultation with a doctor
- (ii) Name and address of doctor
- (iv) Date on which the disease was diagnosed
-

5. THE EMPLOYEE'S EARNINGS AT TIME OF DIAGNOSIS OF THE DISEASE OR WHEN LAST EMPLOYED

Gross cash earnings (Including average overtime and or commission of a regular nature.)

Allowance of a regular nature

(a) Bonuses e.g. 13th cheque)

(b) Other (specify

.....

.....

Cash value of quarters

Cash value of food

Per week R	Per month R
.....
.....
.....
.....
.....
.....
.....

I certify that the information in this form is to the best of my knowledge correct.

.....
Signature of employer or person acting on his/her behalf.

Date: