

Statutory Instrument No. 70 of 2001

WORKER'S COMPENSATION ACT, 1998
(Act No. 23 of 1998)

WORKER'S COMPENSATION (FORMS) REGULATIONS, 2001
(Published on 28th November, 2001)

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IN EXERCISE of the powers conferred on the Minister of Labour and Home Affairs by section 53 of the Worker's Compensation Act, the following Regulations are hereby made —

Citation	1. These Regulations may be cited as the Worker's Compensation (Forms) Regulations, 2001.
Notice to leave neighbourhood	2. The notice of intention to leave the neighbourhood required by section of 17(5) of the Act to be given by a worker to the employer shall be in the form set out in the First Schedule.
Form of list of earnings	3. The list of earnings required by section 18(6) of the Act to be furnished by the employer upon the request of the worker or any duly authorized person acting on his behalf under the Act shall be in the form set out in the Second Schedule.
Report of results of medical examination	4. The results of a medical examination by a medical practitioner under section 10(1) shall be reported in the form set out in the Third Schedule.
Computation of compensation in fatal cases and form thereof	5. (1) Where a worker dies leaving a dependant, or dependants, wholly or partially dependent upon his earnings, in circumstances in which compensation is payable, the amount of compensation to be paid to such dependant, or allocated between such dependants, in terms, of section 13 of the Act, shall be 48 months' earnings, less the reasonable expenses for the burial of the deceased worker payable in terms of sub-regulation (3). (2) Where, in terms of sub-regulation (1), there is more than one dependant entitled to receive compensation, the Commissioner shall determine the degree of dependency of each dependant, and shall allocate the compensation between such dependants, <i>pro rata</i> the degree of dependency of each dependant. (3) The reasonable expenses for the burial of the deceased worker shall be payable from the 48 months' earnings prescribed by sub-regulation (1). (4) The computation of compensation payable in terms of this regulation shall be in the form set out in the Fourth Schedule.
Computation of compensation in cases of incapacity and form thereof	6. (1) Where permanent total incapacity results from injury to a worker in circumstances in which compensation is payable the amount of compensation payable, under section 15 of the Act, shall be 60 months' compensation. (2) Where permanent partial incapacity results from injury to a worker in circumstances in which compensation is payable the amount of compensation payable, under section 16 of the Act, shall be 60 months' compensation multiplied by the percentage of the worker's incapacity. (3) Where temporary incapacity, whether total or partial, results from injury to a worker in circumstances in which compensation is payable the amount of the periodical payments, referred to in section 17(1) of the Act, shall be, or shall be at a rate proportionate to, a monthly payment of two-thirds of the difference between the monthly earnings which the worker was earning at the time of the accident and the monthly earnings which he is earning (or is capable of earning in some suitable employment or business) after the accident. (4) The computation of compensation payable in terms of this regulation shall be in the form set out in the Fifth Schedule.
Application to vary order	7. An application under section 20(2) of the Act to vary an order made thereunder as to the distribution of compensation shall be in the form set out in the Sixth Schedule.

8. The acknowledgement to be provided by the Commissioner in respect of any money deposited with him or other security furnished under section 31(3) of the Act shall be in the form set out in the Seventh Schedule.	Forms of acknowledgement
9. The certificate of insurance required by section 32 of the Act to be issued and delivered by the insurer to the employer shall be in the form set out in the Eighth Schedule.	Form of certificate of insurance
10. Where a policy issued pursuant to this Act is cancelled in any of the circumstances described by section 34(1) of the Act, the insurer shall notify the Commissioner of the cancellation, within 14 days beginning with the day when such cancellation became effective, in the form set out in the Ninth Schedule.	Form of notification of cancellation of policy
11. Where the notice of injury required to be given by section 8 of the Act — (a) is given in writing, it shall be in the form set out in the Tenth Schedule; or (b) is given orally, it shall provide the same information as if it had been in writing.	Form of notice of injury
12. The report of an injury and disease required by section 9(1) of the Act to be made by the employer shall be in the form set out in the Eleventh Schedule.	Form of injury and disease report
13. When a worker is required by section 10(1) of the Act to submit himself for examination by a medical practitioner, the time and place at which the worker is required to attend upon the medical practitioner in pursuance of section 10(2) of the Act shall be notified to him in the form set out in the Twelfth Schedule.	Attendance upon medical practitioner
14. An agreement made under section 38(1) of the Act by the employer and worker as to the compensation to be paid by the employer shall be in the form set out in the Thirteenth Schedule.	Form of agreement as to compensation
15. An application made under section 38(4) of the Act for the cancellation of an agreement made under section 38(1) of the Act, by the employer and worker as to the compensation to be paid by the employer, shall be in the form set out in the Fourteenth Schedule.	Application to cancel agreement as to compensation
16. A requirement addressed to the Commissioner under section 49 of the Act, that any compensation payable to a worker shall be paid by instalments, shall be in the form set out in the Fifteenth Schedule.	Payment of compensation by instalments
17. (1) The insurer or, where he has had recourse to section 31(3) of the Act, the employer shall make a return to the Commissioner — (a) in respect of the period beginning at the commencement of the Act and ending on 31st December, immediately following that commencement; and (b) thereafter, in respect of every period of 12 months ending 31st December, within 30 days immediately after the end of each such period.	Insurer or employer to make certain returns to the Commissioner and form thereof
(2) Every return made under this regulation shall be in the appropriate form set out in the Sixteenth Schedule.	
18. The certificate granted by a medical practitioner under section 21 of the Act in respect of incapacity or death caused by a scheduled disease shall be in the appropriate form set out in the Seventeenth Schedule.	Medical certificate
19. The employer shall, in addition to any compensation payable under regulations 5 and 6, defray such reasonable expenses incurred by a worker as required under section —	Prescribed limits for medical expenses and related costs
(a) 28(1)(a) of the Act, in respect of medical, surgical, dental and hospital treatment, skilled nursing services and the supply of medicines, to an amount not less than P75,000;	

- (b) 28(1)(b) of the Act, in respect of the supply, fitting, maintenance, repair and normal renewal of any artificial appliance, limb, apparatus or mechanical aid, to an amount not less than P10,000; and
- (c) 28(1)(c) of the Act, in respect of reasonable transport charges incurred in transporting the worker to and from a place where facilities for examination and treatment or assessment are available, if such transport is certified to be necessary by the medical practitioner in charge of the case, to an amount not less than P1,500.

Revocation of
Cap. 47:03
Sub. Leg

20. The Workmen's Compensation (Forms) Regulations are hereby revoked.

FIRST SCHEDULE
(Regulation 2)

BL FORM 43/01

WORKER'S COMPENSATION ACT
(Act No. 23 of 1998)
(section 17(5))

**NOTICE OF WORKER'S INTENTION TO LEAVE NEIGHBOURHOOD
OF EMPLOYMENT**

Notice to employer

Full name of employer:.....

Full address of employer:

.....
.....

Description of injury giving rise to periodical payments of compensation and circumstances in which injury suffered:

.....
.....
.....

Amount of periodical payment currently being made: P.....

Date of first payment:.....

Interval of periodical payments: weekly/ fortnightly/ monthly

(Delete as applicable)

Having the intention of leaving the neighbourhood of my employment at the time of suffering the injury in respect of which compensation is currently being paid for the purpose of residing elsewhere, I hereby apply —

for redemption of the periodical payments referred to above by
payment to me of a lump sum/

for continuance of the periodical payments referred to above.

(Delete as applicable)

Date:

Signature of worker:.....

Employer's endorsement of application

I approve the above application and—

in redemption of the periodical payments referred to above offer

the applicant a lump sum of P.....

offer to continue the periodical payments referred to above at the applicant's new place of residence.

(Delete as applicable)

Date:

Signature:.....

(of employer or person acting on employer's behalf)

Worker's acceptance of employer's offer

I hereby accept —

the offer of a lump sum of P.....in
redemption of the periodical payments referred to above/

the offer to continue the periodical payments referred to above at my new place of residence and undertake to make such place of residence known to my employer forthwith.

(Delete as applicable)

Date:

Signature of worker:.....

Reference to Commissioner

Being unable to agree as to the redemption of the periodical payments referred to above or their continuation in the changed circumstances, I hereby apply for a decision on the matter.

Date:

Signature:.....

(of employer or person acting on employer's behalf/worker)

(Delete as applicable)

Decision of commissioner

IN EXERCISE of the powers conferred on me by section 17(5) of the Act, I hereby order —

the payment of a lump sum of Pula.....*

in redemption of the periodical payments referred to above/

**to be stated in words*

continuation of the periodical payments referred to above at the worker's new place's of residence.

(Delete as applicable)

Date:

Signature of Commissioner:.....

SECOND SCHEDULE
(Regulation 3)

BL FORM 43/02

WORKER'S COMPENSATION ACT
(Act No. 23 of 1998)
(Section 18(6))

WAGES OF WORKER

(The expression "wage" or "wages" has the same meaning as in the Employment Act (Cap. 47:01)).

BASIC PAY (whether weekly, fortnightly or monthly)..... P.....

Details of Basic Pay over 12 months immediately preceding accident:

MONTH	BASIC PAY	VOUCHER NUMBER
.....		
.....		
.....		
.....		
.....		
.....		
.....		
.....		
.....		
.....		
.....		
.....		
.....		
.....		
.....		

All other remuneration including over time and other special remuneration (whether by way of bonus or otherwise) if provided on a regular basis: P.....

Average monthly wage(s) (whether paid weekly, fortnightly or monthly) P.....

Date:

Signature of employer or person acting on employer's behalf.

.....

Full name of employer or person acting on employer's behalf

.....

Title of Signatory:.....

cc. TO: Worker

Full Name:.....

Address:

.....
.....
.....

THIRD SCHEDULE
(regulation 4)

WORKER'S COMPENSATION ACT
(Act No. 23 of 1998)
(Section 10)

REPORT OF RESULTS OF MEDICAL EXAMINATION

(To be completed in quadruplicate)

1. Name of worker.....

2. Nature of injury or disease

.....
.....
.....

3. Full particulars of medical treatment including hospitalisation:

.....
.....
.....
.....
.....
.....
.....
.....

4. Percentage of incapacity (see overleaf for % disabilities)

Type	%
(a) Death	
(b) Permanent total*	
(c) Permanently partial	
(d) Temporary (and probable durations.....	

5. If temporary, is worker capable of undertaking light duties?

Yes/No/Not applicable (*delete as necessary*)

6. Will a final examination be necessary before claimant resumes duty?

Yes/No/Not applicable (*delete as necessary*)

In your opinion, will the claimant be able to resume work on which he was employed at the time of the accident? Yes/No/Not applicable (*delete as necessary*)

Date:

Signature:

Designation:

May not be less than 100%. See interpretation section in the Act.

To Worker/Representative/Dependant:

Full Name:.....

Address:.....

.....

.....

Schedule of Percentage Incapacities

<i>Injury</i>	<i>% of incapacity</i>
Loss of two limbs)	
Loss of both hands or of all fingers and thumbs)	
Loss of both feet)	
Total loss of sight)	100
Total paralysis)	
Injuries resulting in being permanently bedridden)	
Any other injury causing permanent total disablement)	
Loss of arm at shoulder	70
Loss of arm between elbow and shoulder	60
Loss of arm at elbow	55
Loss of arm between wrist and elbow	50
Loss of hand at wrist	50
Loss of four fingers and thumb on one hand	50
Loss of four fingers	35
Loss of thumb on both phalanges	35
- one phalange	10
Loss of index Finger - three phalanges	10
- two phalanges	8
- one phalange	4
Loss of middle finger - three phalanges	6
- two phalanges	4
- one phalange	2
Loss of ring finger - three phalanges	5
- two phalanges	4
- one phalange	2
Loss of little finger - three phalanges	4
- two phalanges	3
- one phalange	2
Loss of metacarpals - first or second	3
(additional)	
- third, fourth or fifth (additional)	2
Loss of leg - at or above knee	70
- below knee	60
Loss of foot	40
Loss of toes - all of one foot	15
- great, both phalanges	5
- great, one phalange	2

	- other than great, if more than one toe lost - each	1
Loss of sight of one eye		30
Loss of hearing in one ear		10
Total loss of hearing		50

Scars from injuries or burns which result in disfigurement shall be treated as resulting in from 0 to 50% permanent incapacity according to their size and location.

Total permanent loss of the use of a member shall be treated as loss of such member.

The loss of a sexual organ or other internal organ shall be treated as resulting in from 0 to 75% permanent incapacity depending on the location and effects of such loss.

The percentage of incapacity for ankylosis of any joint shall be reckoned as from 25 to 100% of the incapacity for loss of the part of that joint, according to whether the joint is ankylosed in a favourable or unfavourable position.

Where there is a loss of two or more parts of the hand, the percentage of incapacity shall not be more than for the loss of the whole hand.

Injuries which result in permanent incapacity but which are not included in this Schedule shall be assessed in relation to the percentages of incapacity specified in this Schedule, wherever possible.

FOURTH SCHEDULE (regulation 5)

BL Form 43/04A

WORKER'S COMPENSATION ACT (Act No. 23 of 1998) (Sections 13 and 14)

COMPENSATION IN FATAL CASES

(To be completed in triplicate)

Name of deceased worker.....
Name of employer.....
Address of employer.....
.....
.....
.....
Date of accident.....
Date of death

The compensation payable in the case of death shall be —

- (1) Monthly earnings:
P.....
- (2) 48 months
- (3) Compensation payable: (1) x (2) = P.....
- (4) Reasonable expenses for burial of deceased worker: P.....
- (5) Degree of dependence of each dependant (wholly dependent = 1; partially dependent = 0,1 to 0,9).
- (6) Aggregate of degrees of dependence (for example, if there are two dependants — one wholly dependant and the other partially dependant (determined, for example, by the Commissioner to be 0,6 dependant) - then the aggregate of the degrees of dependence is 1,6).
- (7) Amount of compensation payable to each dependant: (5)/(6) x ((3) - (4)) =

NAME OF DEPENDANT	AMOUNT
.....	
.....	
.....	
.....	
.....	
.....	

Date:..... Signed:.....
For/Commissioner of Compensation

cc. TO: Deceased worker's dependant
Full Name:.....
Address:.....
.....
.....
.....

FIFTH SCHEDULE
(Regulation 6)

BL Form 43/04B

WORKER'S COMPENSATION ACT
(Act No. 23 of 1998)
(Sections 15, 16 and 17)

COMPENSATION IN CASES OF INCAPACITY

(To be completed in triplicate)

Name of worker.....
Address of worker.....
.....
.....
Name of employer:.....

Address of employer:.....
.....
.....

Date of accident.....

The compensation payable shall be —

A. In the case of permanent total incapacity —

- (1) Monthly earnings: P
- (2) 60 months
- (3) Compensation Payable: $(1) \times (2) =$
P.....

B. In the case of permanent partial incapacity —

- (1) Monthly earnings: P.....
- (2) 60 months
- (3) Percentage of incapacity:
- (4) Compensation payable: $(1) \times (2) \times (3) =$ P.....

C. In the case of temporary incapacity (total or partial):

- (1) Monthly earnings at time of incapacitation: P
- (2) Monthly earnings (or capable of earning) while incapacitated:
P.....
- (3) Monthly Compensation: $((1) - (2)) \times 2/3 =$ P.....

Date:.....

Signed:.....
For/Commissioner of Compensation

cc. TO: Worker:

Full Name:.....
Address:.....
.....
.....

SIXTH SCHEDULE

(Regulation 7)

WORKER'S COMPENSATION ACT

(Act No. 23 of 1998)

(section 20(1) and (2))

VARIATION OF DISTRIBUTION OF COMPENSATION

Application to Commissioner to vary apportionment order

Full name of deceased worker:

Date of Commissioner's original order apportioning compensation:

.....

.....

.....

.....

.....

.....

Signature of applicant:

Decision of Commissioner

IN EXERCISE of the powers conferred on me by section 20(1) and (2) of the Act, I hereby—

*decline to make any further order/

*vary the original order referred to above as follows —

.....

.....

.....

.....

.....

*(Delete as applicable)

Date: Signature of Commissioner:

SEVENTH SCHEDULE
(regulation 8)

BL FORM 43/06

WORKER'S COMPENSATION ACT
(Act No. 23 of 1998)
(section 31(3))

ACKNOWLEDGEMENT IN RESPECT OF MONEY DEPOSITED OR OTHER SECURITY FURNISHED IN LIEU OF INSURANCE

Full name of employer:

Full address of employer:.....

.....

.....

.....

Telephone number:

Amount deposited:

(to be stated in words)

or

Security furnished:

.....
.....
.....
.....

(full description to be given)

Date:

Signature:

Commissioner for Worker's Compensation.

Number of receipt issued by Accountant-General in respect of the sum of money/deposit referred to above:

.....

Date:

Signature:

Accountant General.

EIGHTH SCHEDULE
(regulation 9)

BL FORM 43/07

WORKER'S COMPENSATION ACT
(Act No. 23 of 1998)
(Section 32)

CERTIFICATE OF INSURANCE

This is to certify that —

.....
(full name of employer)

of —

.....
(full address of employer)

is fully insured with this company against liability under the Worker's Compensation Act.

Date:.....

Signature:.....

Company seal:

Status of Signatory:.....

(manager, actuary, etc.)

etc.):.....

NINETH SCHEDULE
(regulation 10)

BL FORM 43/08

WORKER'S COMPENSATION ACT
(Act No. 23 of 1998)
(Section 34(1))

NOTIFICATION OF CANCELLATION OR SURRENDER OF POLICY

Name of company or other person to whom certificate of insurance is issued	Date of issue	Cancellation or surrender	Date effective

Date:.....

Signature:.....

Company seal:

Status of signatory:.....

(manager, actuary, etc.)

TENTH SCHEDULE
(regulation 11)

BL FORM 43/09

WORKER'S COMPENSATION ACT
(Act No. 23 of 1998)
(Section 8)

NOTICE OF INJURY

(For use in a claim for compensation by or on behalf of a worker or the dependants of a deceased worker)

To:
(full name of employer)

of:
.....
.....
.....
(full address of employer)

NOTICE IS HEREBY GIVEN that —

.....
.....
.....
(full name, address, job title and other identity particulars of worker)

on the..... day of....., 19.....
(date of accident)

at.....
(place of accident)

incurred injury resulting in incapacity/death and
(delete as applicable)

that the cause of the injury was —

.....
.....
.....
.....
(set out in plain terms the cause of the injury)

AND NOTICE IS HEREBY FURTHER GIVEN that in consequence therefore compensation.
is claimed from you under the Act.

DATED thisday of....., 19.....

Name of person giving notice:
Signature of person giving notice:
Address of person giving notice:

ELEVEN SCHEDULE
(regulation 12)

BL FORM 43/10

WORKER'S COMPENSATION ACT
(Act No. 23 of 1998)
(Section 9(1))

INJURY AND DISEASE REPORT

TO: The Commissioner for Worker's Compensation, or District Labour Officer in whose area the accident occurred.

Name of worker:

Full address:

Occupation:

Date of accident/diagnosis of disease:

Place of accident:

Nature of injuries/disease:

Resulting in: Death (Yes/No)

Permanent Incapacity (Yes/No)

Temporary Incapacity (Yes/No)

Has next of kin been informed? (In case of death only.) (Yes/No).....

Name of employer or person acting on behalf of employer:

Full address of employer/person acting for employer:

Telephone number:

Fax number:

Date:..... Signature:
(of employer or person acting on behalf of employer)

TWELFTH SCHEDULE
(regulation 13)

BL FORM 43/11

WORKER'S COMPENSATION ACT
(Act No. 23 of 1998)
(section 10(1) and (2))

**NOTIFICATION OF TIME AND PLACE OF ATTENDANCE UPON MEDICAL
PRACTITIONER**

TO:.....
(full name of worker)

of—
.....
.....
.....
(full address of worker)

With reference to your notice dated the..... day of, 19....
that you have incurred injury, you are hereby required to present yourself for medical
examination by —
.....
(name of medical practitioner)

who is a medical practitioner nominated by me for the purposes of the Worker's Compensation
Act at —

.....
(place at which medical examination is to be conducted)
on.....
(date on which medical examination is to be conducted)

at
(time at which medical examination is to be conducted)

DATED this day of....., 19.....

Signature:.....
(of employer or person acting on employer's behalf)

THIRTEENTH SCHEDULE
(regulation 14)

BL FORM 43/12A

WORKER'S COMPENSATION ACT
(Act No. 23 of 1998)
(section 38(1))

AGREEMENT AS TO COMPENSATION TO BE PAID BY EMPLOYER

(This form must be completed in triplicate, one copy to be kept by the employer, one copy to be kept by the worker and one copy to be kept by the Commissioner.)

1. (a) Full name of employer:
(b) Full address of employer:
.....
.....
(c) Employer's business:.....

2. (a) Full name of worker:.....
(b) Full address of worker:.....
.....
.....
(c) Worker's occupation:
.....
.....
(set out full details of the nature of the work and duties for which the worker was employed at the date of incapacitation)
(d) Worker's age:.....
(e) Sex:.....
(f) Previous compensation awarded to worker (if any):
.....
.....

3. (a) Date of accident/diagnosis of disease:.....
(b) Cause of accident:
.....
.....
.....

(c) Circumstances and nature of injury or disease:

.....
.....
.....
.....
.....
(set out full details of the injury or disease and state whether incapacity is total or partial, permanent or temporary, and, if partial, the percentage thereof and, if temporary, the duration thereof)

4. Details of contract of employment:

.....
.....
.....
.....
(include the monthly earnings and the value of food, fuel or quarters, if provided)

5. Date of agreement:

6. Amount of compensation agreed upon: P

7. Persons to whom compensation is payable:

.....
.....
.....

8. Amount payable in lump sum: P

Amount and duration of periodical payments: P
(delete as applicable)

9. Any other relevant information:

.....
.....
.....

Signature of worker:

Names and signature of employer or
person acting on employer's behalf

Where the worker is unable to read and understand writing in the language in which the agreement is expressed the following form of certificate should be completed, dated and signed —

I HEREBY CERTIFY that I read over and explained to the worker the terms of this agreement and the worker appeared fully to understand and approve of the same.

Date:

Signature:
(*of Commissioner/Magistrate/ Labour Officer)
(*delete as applicable)

On application being made to him for that purpose, the Commissioner may certify the agreement as follows —

I HEREBY CERTIFY this agreement under section 38(3) of the Worker’s Compensation Act.

Date: Signature:
(Commissioner)

FOURTEENTH SCHEDULE
(regulation 15)

BL FORM 43/12B

WORKER’S COMPENSATION ACT
(Act No. 23 of 1998)
(section 38(4))

APPLICATION TO CANCEL AGREEMENT AS TO COMPENSATION TO BE
PAID BY EMPLOYER

(This application must be completed in triplicate by the party to the agreement seeking its cancellation and forwarded to the Commissioner for Worker’s Compensation)

- 1 . (a) Full name of applicant:
(b) Full address of applicant:.....
.....
.....
- 2. (a) Full name of other party to agreement:
.....
.....
(b) Full address of other party to agreement:
.....
.....
- 3. Date of agreement:.....
- 4. Has the agreement been certified by the Commissioner? Yes/No:.....
(delete as applicable)
- 5. If the agreement has been certified by the Commissioner, the date of his certification:
(If agreement has not been certified by the Commissioner a photocopy of the agreement must be forwarded together with this application.)
- 6. Reasons for seeking cancellation of the agreement:
.....
.....
.....

Decision of Commissioner

IN EXERCISE of the powers conferred on me by section 38 (4) of the Act, I hereby —
cancel the agreement referred to above on the grounds that —

.....
.....
and make the following order in relation thereto —

.....
.....
decline to cancel the agreement.
(Delete as applicable)

Date: Signature of Commissioner:

FIFTEENTH SCHEDULE
(Regulation 16)

BL FORM 43/13

WORKER'S COMPENSATION ACT
(Act No. 23 of 1998)
(section 49)

REQUIREMENT THAT COMPENSATION BE PAID BY INSTALMENTS

*(This form to be completed by the worker requiring compensation to be paid by instalments
and forwarded to the Commissioner for Worker's Compensation.)*

TO: THE COMMISSIONER

1. (a) Full name of worker:
(b) Full address of worker:
.....
.....
2. (a) Full name of employer:
(b) Full address of employer:
.....
.....
3. Date of accident out of which injury arose/diagnosis of disease:
(delete as applicable)

- Date:..... Signature of Worker:

1. Date on which injury/disease reported by or on behalf of employer:
2. Amount of compensation awarded: P
3. Amount of lump sum paid by employer to Commissioner: P
4. Date of payment of first installment:.....
5. Date of payment of last installment: P
6. Total amount of compensation paid to worker: P

.....

.....

.....

.....

.....

Details of any case where death resulted during the year.....(insert year) from injury to a worker but in which compensation was not paid —

.....
.....
.....

Note: Compensation paid in respect of incapacity resulting from injury/disease from which death subsequently resulted must be included in BL Form 43/14B

Date:.....

Names and signature of insurer/employer or person acting on his behalf.

.....

BL FORM 43/14B

WORKER'S COMPENSATION ACT
(Act No. 23 of 1998)

ANNUAL RETURN BY INSURER OR EMPLOYER (WHERE RECOURSE IS HAD TO SECTION 31 (3) OF THE ACT) IN RESPECT OF CASES IN WHICH COMPENSATION WAS PAID FOR INCAPACITY

<i>Name of insurer or employer</i>	<i>Number of cases in which compensation was paid for incapacity during the year (insert year)</i>

<i>Types of cases in which compensation was paid for incapacity during the year(insert year)</i>	<i>Amounts of compensation paid for incapacity during the year(insert year)</i>
Cases continued from previous year	P
Cases in which first payment of compensation was made during(insert year)	P
All cases	P

Date:.....

Names and signature of insurer/employer or person acting on his behalf.

.....

SEVENTEENTH SCHEDULE

(regulation 18)

BL FORM D L/WC A

WORKER'S COMPENSATION ACT

(Act No. 23 of 1998)

(Section 21 (1))

**MEDICAL CERTIFICATE IN RESPECT OF INCAPACITY CAUSED BY
SCHEDULED DISEASE**

TO: Commissioner of Worker's Compensation:

.....
.....
.....
.....

I/We hereby certify that

Mr/Mrs/Miss
(full name of worker)

aged
(age at last birthday or as estimated)

was medically examined by me/us

at
(place at which examination conducted)

on
(date on which examination conducted)

and as a result of the examination and on the basis of my/our acquaintance with his/her medical history I am/we are of the opinion that —

(a) he/she is suffering from a scheduled disease, namely,

.....
.....

(b) he/she is incapacitated as a result of the disease;

(c) the disease was due to the nature of his/her employment, namely,

.....
.....
.....

(d) the disease was contracted not earlier than

.....

(e) his/her incapacity to work is.....%

Remarks:

.....
.....
.....
.....
.....

DATED this..... day of (*month*)..... (*year*).....

Signature(s) of medical practitioner(s) conducting examination:

.....
.....
.....
.....

BL FORM D L/WC B

WORKER'S COMPENSATION ACT

(Act No. 23 of 1998)

(Section 21 (1))

**MEDICAL CERTIFICATE FOLLOWING POST MORTEM EXAMINATION IN
RESPECT OF DEATH CAUSED BY SCHEDULE DISEASE**

TO: Commissioner of Worker's Compensation:

.....
.....
.....
.....

I/We hereby certify that the body of Mr/Mrs/Miss
(*full name of deceased worker*)

aged
(*age at last birthday or as estimated*)

who died/I am/we are informed died on.....
(*date, or date supplied, of death*)

was examined as to the cause of death by me/us
at
(*place at which post mortem examination conducted*)

on.....
(*date on which post mortem examination conducted*)

and as a result of the examination and on the basis on my/our acquaintance with his/her medical history I am/we are of the opinion that —

(a) he/she was, at the time of death suffering from a scheduled disease, namely,

.....
.....

(b) death was caused by the disease;

(c) the disease was due to the nature of his/her employment, namely,

.....
.....
.....

(d) the disease was contracted not earlier than

.....

Remarks:

.....
.....
.....
.....
.....

DATED this day of (month).....(year).....

Signature(s) of medical practitioner(s) conducting post mortem examination:

.....
.....

BL FORM D L/WC C

WORKER'S COMPENSATION ACT

(Act No. 23 of 1998)

(Section 21 (1))

**MEDICAL CERTIFICATE IN RESPECT OF DEATH CAUSED BY
SCHEDULED DISEASE WHERE THERE HAS BEEN
NO POST MORTEM EXAMINATION**

TO: Commissioner of Worker's Compensation:

.....
.....
.....
.....

I/We hereby certify on the basis of our acquaintance with the medical history of Mr Mrs/
Miss

(full name of deceased workman)

aged
(age at last birthday or as estimated)

who died/I am/we are informed died on.....
(date, or date supplied of death)

I am/we are of the opinion that —

(a) he/she was, at the time of death, suffering from a schedule disease, namely,

.....

(b) death was caused by the disease;

(c) the disease was due to the nature of his/her employment, namely,

.....

(d) the disease was contracted not earlier than

.....

Remarks:

.....

.....

.....

.....

DATED thisday of....., 20.....

Signature(s) of medical practitioner(s):

.....

.....

MADE this 6th day September, 2001.

D.K. KWELAGOBÉ,
Minister of Labour and Home Affairs.

L2/7/248 II