SECOND SCHEDULE

WORKMEN’S COMPENSATION ACT
(Substituted by Regulations 6th August, 1976)

NOTICE BY EMPLOYER OF ACCIDENT CAUSING INJURY/DEATH TO A WORKMAN OR DEATH OF A WORKMAN FROM ANY CAUSE WHATSOEVER

(SECTION 14 – REGULATION 3)

PART I

1. EMPLOYER –
   (i) Name………………………………………………………………………………………………………………………………………………
   (ii) Address………………………………………………………………………………………………………………………………………………
   (iii) Industry or Business…………………………………………………………………………………………………………………………
   (iv) Name and address of Insurance Company, if insured against accident to workman…………………………………………

2. WORKMAN –
   (i) Name………………………………………………………… s/o………………………………………………………………………………
   (ii) Sex……………………………………………………………….
   (iii) Age………………………………………………………………
   (iv) Occupation (avoid the term “labourer” where possible)……………………………………………………………………………………
   (v) Residential Address…………………………………………………………………………………………………………………………

3. ACCIDENT/DEATH FROM ANY CAUSE WHATSOEVER –
   (i) Date and Hour…………………………………………………………………………………………………………………………
   (ii) Place………………………………………………………………………………………………………………………………………………
   (iii) Description of accident/death including a clear statement of exactly what the workman was doing at the time of the accident/death……………………………………………………………………………………………………………………………………

4. AGENCY OF ACCIDENT –
   (Put X against appropriate Agency)

   ☐ Electricity ☐ Fire, Hot Substances ☐ Power Driven Machinery ☐ Flying Pieces ☐ Stepping on or striking against objects ☐ Objects falling
   ☐ Person Falling ☐ Handling Material ☐ Handling Tools in use ☐ Vehicles in motion ☐ Animals ☐ Other causes (state what below)

5. INJURY –
   (1) Nature of injury (Put X against appropriate classification)

   ☐ Fractured of crushed limbs ☐ Concussion ☐ Crossed bony consolidation ☐ Traumatic amputation ☐ Burns, scalds
   ☐ Bruises, abrasions, contusions ☐ Cuts, lacerations ☐ Punctures ☐ Sprains, Strains ☐ Dislocation ☐ Foreign Bodies
   ☐ Traumatic amputation ☐ Asphyxiation, gassing ☐ Poisoning ☐ Sepsis ☐ Dermatitis ☐ Not otherwise classified (state nature)

   Name of hospital or medical practitioner treating the injured workman…………………………………………………………

   (2) Action taken……………………………………………………………………………………………………………………………………

6. GROSS WEEKLY EARNINGS AT THE DATE OF THE ACCIDENT –

Gross cash wage: .................................................................
Value of rations: .................................................................
Value of housing: .................................................................
Value of Fuel: .................................................................

Overtime payment or other special remuneration for work done,
whether by way of bonus or otherwise, if of constant character,
and for work habitually performed: .................................................................

Total gross earnings per week: .................................................................

Date: .................................................................

Signature of employer: .................................................................

Notes –

(1) In the case of injury to a workman involving incapacity for work for three or more consecutive days it is requested that the employer complete Part I in quadruplicate and then despatch it immediately as under:

- Original – To the Permanent Secretary for Labour, Suva.
- Duplicate, Triplicate and Quadruplicate – To the medical practitioner attending or examining the injured workman.

(2) In the case of an accident causing the death of workman or death resulting from any cause whatsoever Part I should be completed in quadruplicate and then despatched as in (1) above.

The submission of this notice does not itself constitute a liability to pay compensation.

PART II

(For use by the medical practitioner attending or examining the injured workman)

Date admitted to hospital: .................................................................
Discharged: .................................................................

Inpatient No.: .................................................................

Attendance as out-patient from: .................................................................
Out patient No.: .................................................................
Nature of injury: .................................................................

Permanent incapacity: ................................................................. percent
Temporary incapacity – Likely duration of absence from work (from date of accident) ................................................................. days/weeks/months.

Is a further examination required before final assessment of permanent incapacity can be given? .................................................................

If so, when: .................................................................

Date: .................................................................
Name of Medical Practitioner: .................................................................
Signature: .................................................................

Note – it is requested that this part be completed by the medical practitioner in triplicate, the form being despatched as under:

- One copy to the employer
- One copy to the Permanent Secretary for Labour, Suva
- One copy to be retained by the Medical Practitioner

PART III

(For use of Permanent Secretary for Labour)

Compensation *is/is not being claimed on behalf of the *workman/dependants of the deceased workman.

District and Accident Register No.: .................................................................
Station: .................................................................

Date: .................................................................

* Delete as necessary

Secretary for Labour: .................................................................