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THE WORKERS COMPENSATION ACT
(CAP. 263)

REGULATIONS

(Made under section 94)

THE WORKERS COMPENSATION (AMENDMENT) REGULATIONS, 2021

Citation

GN. No. 185 of 2016

1. These Regulations may be cited as the Workers Compensation (Amendment) Regulations, 2021 and shall be read as one with the Workers Compensation Regulations, 2016, hereinafter referred to as the "principal Regulations".

Amendment of regulation 13

2. The principal Regulations are amended in regulation 13, by deleting the word "ten" in sub-regulation (7) and substitute for it the word "two".

Amendment of regulation 26

3. The principal Regulations are amended in regulation 26(1) by-

(a) deleting paragraph (g), (h), (i) and (j);
(b) adding the word "and" at the end of paragraph (e);
(c) deleting the comma after the full stop appearing at the end of paragraph (g); and
(d) adding immediately after sub-regulation (2) the following:

"(3) The Director General may, where any of the criteria under sub-regulation (1) is not complied, refuse to pay the compensation."

Amendment of regulation 36

4. The principal Regulations are amended in regulation 36 by-

(a) deleting the figure "3,685,852.69" appearing in sub-regulation (2) and substituting it with figure "8,400,000.00";

(b) deleting sub-regulation (3) and substituting for it the following:

"(3) The compensation for temporary partial disablement shall be calculated based on the amount of compensation for temporary total disablement proportionate to the degree of temporary disablement at the time of occurrence of accident subject to a maximum amount of shillings 8,400,000.00 and the minimum amount calculated on the portion of either shillings 275,702.83 or seventy percent of an employee's monthly earning whichever is higher."

(c) adding immediately after subregulation (3) the following:

"(4) The maximum and minimum amounts referred in subregulations (2) and (3) may be revised by the Minister after considering the financial sustainability of the Fund.".

Amendment of regulation 38

5. The principal Regulations are amended in regulation 38 by-

(a) deleting the figure "3,685,852.69" appearing in subregulation (2) and substituting it with figure "8,400,000.00";

(b) deleting subregulation (3) and substituting it the following-

"(3) The compensation for the employee who sustained permanent partial

disablement of more than thirty percent, shall be calculated based on the amount of compensation for permanent total disablement proportionate to the degree of disability at the time of occurrence of accident subject to a maximum amount of shillings 8,400,000.00 and the minimum amount calculated on the portion of either shillings 275,702.83 or seventy percent of an employee's monthly earning whichever is higher.

(c) adding immediately after subregulation (3) the following:

"(4) The compensation for the employee who sustained permanent partial disablement of thirty percent or less, shall be paid in form of a lump sum and the amount payable shall be eighty-four times the monthly pension calculated based on the amount of compensation for permanent total disablement proportionate to the degree of disability at the time of occurrence of accident subject to a maximum employee's earning of shillings 8,400,000.00 and the minimum employee's earnings calculated on the portion of either shillings 275,702.83 or seventy percent of an employee's monthly earning whichever is higher.

(5) The maximum and minimum amounts referred in sub-regulations (2), (3) and (4) may be revised by the Minister after considering the financial sustainability of the Fund."

Amendment of regulation 41

6. The principal Regulations are amended in regulation 41(1) by-

(a) deleting items (i) and (ii) of paragraph (a) and substituting for them the following:

(i) a lump sum based on twice the monthly pension provided under section 48(4)(a)

of the Act, subject to a minimum of shillings 551,405.66 and maximum of shillings 16,800,000.00"; or

(ii) monthly pension based on the forty percent of the monthly pension provided under section 48 (4) (a) of the Act, subject to a minimum of shillings 110,281.13 per month and maximum of shillings 3,360,000 per month."

(iii) the maximum and minimum amounts referred in items (i) and (ii) may be revised by the Minister after considering the financial sustainability of the Fund."

(b) deleting items (i) of paragraph (b) and substituting for it the following:

(i) a monthly pension based on twenty percent of the monthly pension as stated under section 48(4)(a) of the Act, provided that the Director General approves such payment to be effected to the latter subject to a minimum of shillings 55,140.57 per month and maximum of shillings 1,680,000.00 per month;

(ii) the maximum and minimum amounts referred to in item (i) may be revised by the Minister after considering the financial sustainability of the Fund." and

(c) renumbering item (ii) as item (iii) appearing in paragraph (b);

(d) deleting items (i) and (ii) appearing in paragraph (c) and substituting for them the following:

(i) not exceeding forty percent of the monthly pension as provided under section 48(4)(a) of the Act, shall be paid for the dependant who wholly depended upon the deceased subject to a minimum of shillings 110,281.13 per month and maximum of shillings 3,360,000.00 per month;

(ii) not exceeding twenty percent of the monthly pension as provided under section 48(4)(a) of the Act, shall be paid for the dependant who partially depended upon the deceased subject to a minimum of shillings 55,140.57 per month and maximum of shillings 1,680,000.00 per month;

(iii) the maximum and minimum amounts referred in items (i) and (ii) may be revised by the Minister after considering the financial sustainability of the Fund."

Repeal of regulation 51

7. The principal Regulations are amended by-
(a) repealing regulation 51; and
(b) renumbering regulations 52 to 61 as regulations 51 to 60 respectively.

First Schedule

8. The principal Regulations are amended in the First Schedule by deleting Form WCN-1 (Notification Form for Occupational Accidents, Diseases or Deaths), Form WCC-2A (Initial Medical Report), and Form WCC-2B (Medical Practitioner's Report) and substitute for them the following:

Employee's WCF No……………… *WCN-1*

NOTIFICATION FORM FOR OCCUPATIONAL ACCIDENTS, DISEASES OR DEATHS

(Made under regulations 15 and 16)

(To be completed by an employee, employer or any person on behalf of an employee in triplicate)

A. TYPE OF NOTIFICATION (mark (√) appropriately)

Occupational accident (Fill part B, C, D & G)		Occupational disease (Fill part B, C, E & G)		Death (Fill part B, C, F & G)	

B. EMPLOYER'S PARTICULARS

Name of employer……………………………..……………………………………………………
State Public or Private? ……………………….........WCF Reg. No ………………………
Contact address………………………………....................
Country…………………………..................
District……...…………………….
Region……………………………Street/Village…………………....
Tel ……………………………………………… Cell phone…….…………………....
E-mail…………………………………………………………………………………

C. EMPLOYEE'S PARTICULARS

First Name……………………Middle Name ………………Last Name……………..……..
National ID …………………………….…. Employee's Employment ID ….............
Employment status (Unspecified period, Specified period, Specific task/Casual) ………………………………
Job title ……………….......... Section/Department……….……………………………..
Date of birth…………Sex……. Marital Status…….…No. of Children.…………………
Contact address……………………... District………………. Region …………………….
Nationality……….……………………………………………………………………………
Tel…………………... Cell phone……………...…E-mail……………………………….
Next of kin's Name……….…………. Next of Kin's Cellphone...……........................

D. PARTICULARS OF OCCUPATIONAL ACCIDENT

Date of accident………….….… Time of accident (AM/PM) ………………………….
Date of reporting the occurrence of an accident to the employer………………………….
The specific part of body injured ……………………………….……………………….
Place of accident (street, ward, city) …………………...
Did the accident occur on the employer's premises? (Yes/No) ………Section/ department …………………….
Specific activity the employee was performing at the time of accident...…………………………...…….

Briefly describe the sequence of events and specify the object which directly produced/caused the injury
……………………………………………………………………………………..........................
…………………………………………………………………………………………………
…………………………………………………………………………………………………
Witness (s): -

1. Name………………………………Cell Phone ……………………………...
2. Supervisor's name…………………Cellphone…………….Section/Department…….

Initial treatment date ……………... Name of treating Hospital……………………….

E. PARTICULARS OF OCCUPATIONAL DISEASE
Date of diagnosis……………..... Occupational disease diagnosed …………….…………
Date of reporting disease to employer………………………………………………….
Section/Department where exposure occurred on employer's premises………………...
Briefly describe the sequence of activities associated with the disease diagnosed…..…………………………………...
…………………………………………………………………………………………………
…………………………………………………………………………………………………
Name of the Hospital where the diagnosis was established……….…………….………
Name medical practitioner who diagnosed the disease……………………….………...
…………………………………………….........Cellphone No. ………….………
(*Attach diagnosis reports*)

F. PARTICULARS OF DEATH (mark (√) appropriately)
Name of employee's representative……...…………………………………
Cellphone No. …………………………………………………….……….
The physical address of the employee's representative
………………...…………….………………………
Date of death……………………………………………………………….
Cause of death - occupational accident ( ) or occupational disease ( )
Date of reporting to the employer ……………………..…………………………..
Place where Death occurred (street, ward, city)
………..…........
Did the incident occur on the employer's premises? (Yes/No) ……..... Section/Department
…………………………………………………………..……..
Specific activity the deceased employee was performing when event/exposure occurred
...…………………………………………………………………
Briefly describe the sequence of events /exposure and specify object/exposure which directly produced the accident/ disease that led to his /her death…………………..........
………………………………………………………………………………………………
Name of the hospital where death was confirmed.……………………. ………………..
Name of Medical practitioner who confirmed death ……..…Cellphone No………………

PART: G
EMPLOYEE'S DECLARATION

I, ……………………………………………………………., declare that what I have stated hereinabove is true to the best of my knowledge and if it is proved that there is

forgery or fraud in relation to the information provided, legal action should be taken against me.
Signature……………………………………………………………………………….
Date………………………………………………………………………………………

EMPLOYER'S ACKNOWLEDGEMENT OF RECEIPT OF NOTIFICATION

Date of receipt of the notification by the employer	Notified by (Name and designation)	Received by (Name, designation, signature and official stamp)

I, ………………………………………………………………, declare that the information provided hereinabove is true to the best of my knowledge.

Employee's WCF No…………………… *WCC-2A*

INITIAL MEDICAL REPORT

(Made under regulation 21(1))

(This form shall be filled by a medical practitioner in triplicate)

A. EMPLOYEE'S PARTICULARS
First Name…………………. Middle Name ……………. Last Name ……….……….

Date of birth………… Medical File no……………. Job Title…….………………….
Employer's Name.………………………………. Employee's ID No…………….

B. PARTICULARS OF HEALTH CARE PROVIDER
Name of health care provider ……………………………………………………...

Contact address …………………………… Region/District …….……….……………...

C. PARTICULARS OF OCCUPATIONAL ACCIDENT OR DISEASE

i. Date of accident or diagnosis of occupational disease…………… (DD/MM/YY)
ii. Date of the first consultation at this facility…….…………...…(DD/MM/YY)
iii. Description of injuries/condition of the employee at the time of examination
…………………………………………………………………………………
…………………………………………………………………………………
……………………………………
iv. Diagnosis………………………………………………………………………
…………………

D. MEDICAL PRACTITIONER'S ASSESSMENT

i. Does the employee require hospitalization? (Yes/No). *Circle appropriately*
If Yes, which unit? …………………………..…
ii. Does the employee require a follow-up visit? (Yes/No). *Circle appropriately*
If Yes, when is the next visit? ……./……/…….. (DD/MM/YY)
iii. Is the employee able to resume his duties? (Yes/No). *Circle appropriately*
If No, exempted duty days………..…; From:……..…. To: ……..……….
Reason:
…………………………………………………………………………………
light duty days………...; From: ………………. To: ………
Reason: ……………………………...

iv. Medical Practitioner's remarks (*if applicable, attach a medical report*)
…………………………………………………………………………………
…………………………………………………………………………………
…………………………

GN. NO. 668 (Contd.)

DECLARATION

I declare that what I have stated hereinabove is true to the best of my knowledge.

Name of medical practitioner……………………. Designation ………………………

Registration No……………... Cell phone……………… E-mail…………………………...

Signature……….................... Date……………….......................... (DD/MM/YY)

Official stamp

GN. NO. 668 (Contd.)

Employee's WCF No……………………. *WCC-2B*

MEDICAL PRACTITIONER'S REPORT

(Made under regulation 21(2))

(This form shall be filled by a medical practitioner in triplicate)

A. EMPLOYEE'S PARTICULARS

First Name………………. Middle Name ………………. Last Name …………………….
Medical File no…………………… Employer's Name. …………………………………

B. PARTICULARS OF HEALTH CARE PROVIDER

Name of health care provider ….…………………………………………………...

Contact address …………….…………… Region/District …….……………………...

C. DETAILS OF SERVICES RENDERED

i. Hospitalisation (fill appropriately)

Date of Admission (DD/MM/YY)	Date of Discharge (DD/MM/YY)	Reason

ii. Medical investigations, procedures and surgeries done

a) Investigations……………………………………………………………….…
b) Procedures………………………………………………………………….
c) Surgeries

Date of surgery (DD/MM/YY)	Type	Indication (s)	Anaesthesia	Surgeon's name and qualification

D. CURRENT STATE OF EMPLOYEE (PATIENT) (MARK (√) IN THE APPROPRIATE BOX)

i. Employee status

Fully recovered (Resumed duties without permanent loss of body part/function)	Recovered with permanent loss of body part/function (Go to the table (ii) below)	Need medical follow up (Outcome not yet fully decided)	Death (Cause of death)

ii. For permanent loss of body part (s) or function (s) (complete table below)

Body part or function(s) impacted/affected	Manner of loss	Degree of Functions impaired or Level of loss of body part	Rehabilitation recommended

GN. NO. 668 (Contd.)

iii. Date when declared fit returning to work with /without restrictions……/……/…... (DD/MM/YY)

E. FINAL DIAGNOSIS

i. What is the final diagnosis?
……………………………………………………………….………………...

ii. Do you think this condition is occupational? (Yes/No). *Circle appropriately.*
Why?
………………………………………………………………………...………………………

iii. Medical practitioner's opinions and recommendations (*in case of referral please advise here*)

……………………………………………………………………………………………………

……………………………………………………………………………………………………

DECLARATION

I declare that what I have stated hereinabove is true to the best of my knowledge.

Name of medical practitioner…………………………. Designation ………………………

Registration No……………... Cell phone……….……… E-mail……………………...

Signature……….................... Date…………………............................... (DD/MM/YY)

Official Stamp

Dodoma,
20th August, 2021

JENISTA J. MHAGAMA
Minister of State, Prime Minister's Office,
Policy, Parliamentary Affairs, Labour, Youth,
Employment and Persons with Disability