Employee's WCF No …… ***WCN-1***

NOTIFICATION FORM FOR OCCUPATIONAL ACCIDENTS, DISEASES OR DEATHS

(Made under regulations 15, 16 and 17)

(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 occurrence of an accident to the employer…….

Specific part of body injured ……..

Place of accident (street, ward, city) …….....

Accident occurred on employer's premises? (Yes/No) ……Section/ department …….

Specific activity the employee was performing at the time of accident...……...…….

Briefly describe sequence of events and specify 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 sequence of activities associated to 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. …...……..
Physical address of 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) …….....
Incident occurred on employer's premises? (Yes/No) ….. Section/Department ……..
Specific activity the deceased employee was performing when event/exposure occurred ...…….
Briefly describe sequence of events /exposure and specify object/exposure which directly produced the accident/ disease that led to his /her death…….....
……..
Name of 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 herein above 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 notification by employer	**Notified by (Name and designation)**	**Received by (Name, designation, signature and official stamp)**

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