WCN-1

WORKERS COMPENSATION FUND
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		Occupational disease		Death	

B. **EMPLOYER'S PARTICULARS**

Name of employer……..…….....
WCF Reg. No ……..
Contact address…….....Street/Village…….....
District……...…….Region……Country……...
Tel ……..Fax……Cell phone……..……
E-mail……...

C. **EMPLOYEE'S PARTICULARS**

Name of employee ……...……..…….
Employee's Code No. ……National ID ……...Employee's ID …….
Job title …….....Section/Department……..……..…
Date of birth……Sex…… Marital Status……..……No. of Children……..…..
District……...……. Region ……..……..Nationality……..……..…
Street/Village ……..Plot No…… Block No……...……
Tel……...Fax…….…….. Cell phone……...……
E-mail…….. Next of kin……..……..

D. **PARTICULARS OF OCCUPATIONAL ACCIDENT**

Date of accident……Time of accident……Place of accident……...…..…….
Date of reporting occurrence of an accident to the employer……..
Activity/Duty performed at the time of accident
…….……..……..……
Describe in brief how accident occurred ……
……
……..
Witness (s):-

1. Name……Cell Phone ……...
2. Name……Cell Phone ……...
3. Name…….…...Cell Phone ……..

Supervisor's name …….……....Section/Department……

E. **PARTICULARS OF OCCUPATIONAL DISEASE**

Date of diagnosis……..Occupational disease diagnosed ……..……..
Date of reporting disease to employer…….
Name of the health care provider where the diagnosis was established……
Name and address of medical practitioner who diagnosed the disease…….
……
……
……

F. **PARTICULARS OF DEATH (mark (√) appropriately)**

Name of employee's representative……..……..…….
Contact and physical address of employee's representative ……..…….
……..
Date of death…… …….. Place of death ……....
Cause of death - occupational accident ( ) or occupational disease ( )
Date of reporting to the employer ……..
Medical practitioner (name and contact address)
……..
……..
……..
……..

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.

Name……
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.