WCC-2A

WORKERS COMPENSATION FUND
INITIAL MEDICAL REPORT

(Made under regulation 21(1))

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

A. TYPE OF MEDICAL REPORT (Mark (√) appropriately)

Occupational Accident		Occupational Disease	

B. EMPLOYEE'S CONSENT

I, ……., wilfully agree my medical information contained herein to be used in determining my claim for compensation.

Name ……Date ……Signature ……..

C. EMPLOYEE'S PARTICULARS

First Name…….. Middle Name ……. Last Name …….
Job title……
Date of birth……Employee's code No. ……Employee's ID No…….

D. PARTICULARS OF OCCUPATIONAL ACCIDENT OR DISEASE

i. Date of first examination of employee in case of accident…….
ii. Nature of injuries……
……
……
……
iii. Occupational disease diagnosed……
iv. Date of diagnosis ……
v. Health care provider in which an employee was first examined or an occupational disease was established.
Name of health care provider ……..
Contact address ……...……Region/District ……..……...

E. MEDICAL PRACTITIONER'S ASSESSMENT

i. Condition of an employee at the time of first examination after occurrence of an accident or establishment of an occupational disease
……
……
……
……

ii. Current condition of an employee
……...
……...
Name of medical practitioner……..Designation ……Reg No……..
Address……... Cell phone……
E-mail……..Signature…….....Date……...

Official stamp