labour

Department:
Labour
REPUBLIC OF SOUTH AFRICA

Claim Number: .....

RESUMPTION REPORT

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 (ACT NO. 130 OF 1993)

N.B.: This form must be completed and submitted by the employer immediately after the employee has resumed work or was discharged. If on prolonged treatment monthly resumption reports must be submitted until such time the employee is discharged or returns to work.

Names and Surname of employee .....

Identity Number ..... Address: .....

..... Postal Code .....

Name of employer .....

Address .....

..... Postal Code .....

Date of accident .....

State the period(s) the employee was *off duty* or performing *light duty*	From		To		Advances / salary paid to the employee for the periods indicated at item 1
	Date	**Time**	**Date**	**Time**	
1. PERIOD(S) OFF DUTY					
2. PERIOD(S) PERFORMING LIGHT DUTY					

3. Was light duty available and offered to the employee? YES / NO .....
4. Did the employee perform **recommended** light duty? YES / NO .....
   (If **not**, give reason). .....
5. **If yes**, what percentage of normal was the light duty performed worth to the company **e.g. 20%, 40%**, etc. or indicate the rate of earnings paid whilst performing light duty. .....
6. Is the employee still in your employment? YES / NO .....
7. (a) The employee left my service on (date) .....
   (b) The employee's present address is. .....
8. Did the employee receive free food and/or quarters from you during the period(s) mentioned in paragraph 1 above? If so, state the period(s) hereunder at paragraphs (a) and/or (b).

   (a) Food From ..... To .....
   (b) Quarters From ..... To .....
9. Period detained in hospital From ..... To .....

I hereby declare that the particulars furnished in the foregoing report are true and correct.

Signature of Employer .....

Name (Printed) .....

Date (important) .....

Call Centre No.: 086 010 5350 - Fax No.: (012) 323-8627 or (012) 323-6986
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