ML/DOSH/FORM 1

REPUBLIC OF KENYA

DIRECTORATE OF OCCUPATIONAL SAFETY AND HEALTH SERVICES

NOTICE BY EMPLOYER OF AN OCCUPATIONAL ACCIDENT/DISEASE OF AN EMPLOYEE

PART 1

1. Employer/Occupier Particulars:-
   - ii. Name of Employer/Occupier……
   - iii. WIBA* registration No……OSHA* Registration No. ……
   - iv. Full Address P. O. Box……Physical Location…..……..……
   - v. E- Mail address…… Tel……..……
   - vi. Nature of Work ……..…….
   - vii. Name and address of Insurance Company which has insured employee against accident

     ……..……..…

     ……..……

2. The Injured/sick employee's particulars :-
   - i. Name……..……
   - ii. Sex……
   - iii. Age……..……
   - iv. Occupation ……...……
   - v. Full Address…… ……..…… ……..
   - vi. E- Mail address……Tel: ……..……
   - vii. Identity Card No. *(Incase of fatal injury, Death Certificate No.)…….……
   - viii. Home County: ……..…….. District: ……..…… Division: ……

     Location: ……..…… Sub-location …….……..…..

3. Occupational Accident
   - i. Date of Accident …… Time: ……Fatal /Non fatal ……...…..
   - ii. Has the worker resumed working Yes/No ……..Date of resumption ……...…..
   - iii. Place where accident took place……..
   - iv. What is the injured worker's Occupation…….……..
   - v. What duties was the employee undertaking at the time of the accident? ……..……..
   - vi. Length of service with the present employer…….……..
   - vii. What work is the worker employed to undertake…….…..
   - viii. Cause of Injury……..……..
   - ix. Type of Injury ……..……..
   - x. Part of Body Injured……..……..

4. Occupational Disease

   Detail about the Occupational disease affecting the employee.
   - i. Date of diagnosis of the occupational disease …….……
   - ii. Name of medical practitioner who made the diagnosis ……..……
   - iii. Date the employer was notified of the disease by the employee or medical practitioners…..……
   - iv. Describe the Cause of the occupational disease ……..……

     ……..……

     ……..

5. Total Monthly earning at the date of the Accident/disease:-

   Salary/wage .. .. Sh. ……..……

   Allowances paid regularly (including house, medical etc) ... . Sh……..……..……

   Overtime payment or/and other special remuneration for work done whether by way of bonus otherwise if of constant character and for work habitually performed.. .. Sh. ……..……..……..

   Total earning per month . .. . … Sh……

   Total earnings paid to the employee during the period of incapacity .. .. .. Sh……

Name of Employer or person notifying on behalf of Employer ……..Signature …….

Designation ……..… Date ……

Note:-

1. In the case of injury to an employee involving incapacity for work for three or more consecutive days, it is requested that the employer complete Part 1 in triplicate and then dispatch the forms immediately as hereunder:
   One copy: - To the Occupational Health and Safety Officer in charge of the District in which the accident occurred.
   2 copies: - To the medical practitioner attending or examining the injured/sick employee. The forms to be forwarded to the Occupational Health and Safety Officer immediately the doctor completes part II
2. Please attach any evidence detailing any payment forming part of the employee's total earning that the employee has been paid during the period of temporary disablement when he/she was out of work as a result of the injury.
3. Indicate who has paid for the medical bills
4. In the case of an occupational accident/disease causing the death of an employee, Part 1 should be completed in duplicate and then dispatched as hereunder:
   One copy: - Immediately to the Occupational Health and Safety Officer in charge of the District in which the death occurred.
   The other copy together with a copy of the death certificate:- to the Occupational Health and Safety Officer in charge of the District in which the death occurred.
5. The original form should be filled as original on both pages (not carbon copied).

PART 11 (for use by the Medical Practitioner)

MEDICAL REPORT

Name of employee…….
Date admitted to hospital……...Discharged……
In-patient No. ……
Attendance as out-patient from……..…..to…….
Out –patient No. ……
Type of injury…….or
Occupational disease ……
Is there permanent incapacity?.....*Yes/No
If yes please give:

a) Details and nature of permanent incapacity…… ….
   ……..……..
   ……
   ……
b) Percentage of permanent incapacity to be indicated in both words and figures(***reference must be made to the first and second schedule of the Work Injury Benefit Act No. 13 of 2007***)…….……
   …….
   ……..……
   ……per cent.

Temporary incapacity :-(Duration of absence from work in days, from the date of injury or acquiring occupational disease/or diagnosis of occupational disease to the time of resumption of duty or death.)…….(employee's working days)
Is a further examination required before final assessment of permanent incapacity can be given?.....If yes ;
a) which ones ....
   .....
b) when?.....
c) Who paid the medical bills paid (Employee or Employer)…… ……..
Name of Medical Practitioner……KMP&DB No.…… ……..
Signature ……..……..Date ……
Name of Hospital/Clinic/Private Practice…….

PART 111

(For use by Occupational Health and Safety Officer)

Compensation *is / is not being claimed on behalf of the employee/dependants of the deceased employee.
District and Accident Register No……..……..……..

Station……..…….. Date…….

…… …..……
Occupational Health and Safety Officer

*Delete whichever is inapplicable