# DECLARATION BY EMPLOYER OR AUTHORISED PERSON

I hereby declare that the particulars, shown in items 1 to 40 of this report, of an alleged occupational disease contracted by the employee, are to the best of my knowledge and belief true and accurate

Signed on this_____ day of _____ 20_____ SIGNATURE_____

**EMPLOYER**

1. Registered name with the Compensation Commissioner_____
2. Registration number of this business with the Compensation Commissioner
3. Contact person _____
4. Street address _____ 5. Postal address _____
6. Postal code _____ 7. Postal code _____
8. Tel (___) _____
9. Fax (___) _____ 10. Situation of business/farm_____
11. Nature of business, trade or industry_____

**EMPLOYEE**

12. Surname _____ 13. First names _____
14. Id. No. _____ 15. Date of birth __/__/____ 16. Sex male/female
17. Marital state married/single _____ 18. Citizen of _____
19. Personnel No. _____ 20. Occupation _____
21. Street address _____
22. Postal code _____
23. Period in your employ (years/months)_____
24 Is the injured employee a working director, working member of a CC, owner of or a partner in the business?_____

**OCCUPATIONAL DISEASE**

25. Nature of disease_____
26. Date the disease was diagnosed_____
27. Alleged cause of disease_____

(State the agent present in the work-place and with which he had contact that caused the disease)

28. For how long a period was he exposed_____
29. Date employee reported the disease_____
30. Please mention the name and address of the employer if the employee did not contract the disease in your employment

**PARTICULARS OF EMPLOYEE** W.CL. 1(E)

| | R/week | R/month |
|---|---|---|
| 32. Earnings at the time of the diagnosis of the disease | | |
| Gross cash earnings | | |
| (Including average payments for overtime and/or commission of a constant character) | | |
| Allowances of a recurrant nature: | | |
| (a) Bonuses (i.e. 13th cheque) | | |
| (b) Other (specify) | | |
| Cash value of food | | |
| Cash value of free quarters | | |

33. Will the employee during temporary total disablement continue to receive from you:

| | | |
|---|---|---|
| Free Food? | Yes | No |
| Free Quarters? | Yes | No |

34. Are you prepared to make cash payments during temporary disablement that lasts longer than three months?

| | |
|---|---|
| Yes | No |

35. If you have already paid cash to the employee, state the total amount R_____
36. For what period were such payments made? From __/__/__ to __/__/__
37. Date on which employee ceased work __/__/__ Time _____
38. Date on which the employee resumed work _____
    [If employee has not yet resumed work, a Resumption report (W.CL. 6) must be submitted as soon as he resumes duty]

**FURTHER PARTICULARS**

39. If the employee did to your knowledge receive compensation previously for the same disease or another disease in respect of an accident, give particulars _____

40. Was the disease caused by the employee's -
    (a) Deliberate non-compliance of directions Yes/No
    (b) Reckless disregard of the terms of any law or statutory regulation designed to ensure the safety or health of employees or the prevention of diseases Yes/No

    (N.B.: If any reply is in the affirmative, the employee must furnish an explanatory statement which must then be attached hereto together with your comments thereon.)