

ACCIDENT REPORT FORM

The information required in this form will enable RMA to determine the claimant's eligibility to qualify for compensation.

Report of an Accident and Claim for Compensation

- 1 This form is to be completed by the employer and forwarded to RMA within 7 days in respect of all accidents that arose out of and in the course of the employee's employment and which resulted in personal injury, illness or death of the employee.
- 2 In cases of broken spectacles or dentures, road accidents, assaults or sports accident claims, the relevant questionnaire and supporting documents should accompany this form.

RMA Claim No:

EMPLOYER DETAILS

Employer Name																			
RMA Member No																			
Injury	☐	Yes	☐	No	☐	Fatality	☐	Yes	☐	No	☐	Date of Death	☐	Y	Y	M	M	D	D
Employer Accident Reference No.	☐	☐	☐	☐	☐	Year	☐	☐	☐	☐	☐	Accident No.	☐	☐	☐	☐	☐	Shaft	☐

ACCIDENT DETAILS

Date of Accident	☐	Y	☐	Y	☐	M	☐	M	☐	D	☐	D	Time of Accident :	☐	H	☐	H	☐	M	☐	M		
Mark the accident location that best describes where the event occurred	Surface												Below Ground										
	Other (Specify)																						
Did the accident occur at the employee's normal work place											Yes	☐	No	☐									
How did the accident occur ? Details are to include the location and the employee's activity at the time of the accident:																							

Injury details (Specify the nature of the injury, the body part/s injured, and whether the injury is on the right side, left side or both sides (e.g. lacerated thumb right side)

Nature of Injury																
Injured body part/s																
In the same accident, how many other employees were:											Injured	☐	Killed	☐	Total	☐

EMPLOYEE DETAILS

Title (Mr; Mrs; Ms)											First Names																					
Surname																																
ID/Passport No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐												
Country											Date of Birth	☐	Y	Y	M	M	D	D														
Employee Number											Industry No.																					
Residential Address																																
Town/City											Postal Code																					
Postal Address																																
Town/City											Postal Code																					
Contact Details											Telephone No																					
Email Address																																
Marital Status	Married					☐	Single					☐	Divorced					☐	Widowed					☐								
Gender	Male					☐	Female					☐																				
Place of Origin	Province															Country																
Occupation											Employment Category											Misco Code										
Total number of years working in industry:																																
Date of employment	☐	Y	☐	Y	☐	M	☐	M	☐	D	☐	D	Length of service in present occupation																			

DECLARATION BY EMPLOYER

I hereby certify that the employee described in this form was in the company's employment at the time of the accident described, and that the particulars shown in this form are to the best of my knowledge and belief true and accurate.

Name of Authorised Signatory											Signature										
Designation											Date	☐	Y	Y	M	M	D	D			

