GAUTENG PROVINCE
EDUCATION
REPUBLIC OF SOUTH AFRICA

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THRS INTERNAL MEMORANDUM NO 48 OF 2023

TO: **ALL GAUTENG DEPARTMENT OF EDUCATION EMPLOYEES**
PRINCIPALS OF PUBLIC SCHOOLS

CC: **ORGANIZED LABOUR**
DISTRICT DIRECTORS
BMT MEMBERS

FROM: **MS DORAH MOLOI**
CD: TRANSVERSAL HUMAN RESOURCE SERVICES

DATE: **17 OCTOBER 2023**

SUBJECT: REGISTRATION OF INJURY ON DUTY (IOD)

1. PURPOSE

The purpose of the Memorandum is:

1.1 To inform GDE employees to report any personal injury by Colleagues/Supervisor/Manager within 24 hours from its date of occurrence.

1.2 The IOD Advisors are the Deputy Directors in Transversal HR Services in the Districts and Head Office.

1.3 In terms of Compensation for Occupational Injuries and Disease Act, No. 103 of 1993, as amended

(a) An occupational injury is an injury caused by an accident arising out of and in the course of an employee's employment.

(b) and resulting in a personal injury requiring medical aid or resulting in disability or death and does not include an occupational disease in any form except if that occupational disease results from an occupational injury.

SUBJECT: REGISTRATION OF INJURY ON DUTY (IOD)

1.4 Upon the employee been treated for the incident/accident, the affected employee should:

I. Register the case by completing W.CI.2
II. Submit progress/final report by treating Doctor

1.5 The Compensation Commissioner is liable for payment of medical costs for not more than 24 months, after adjudication of the case has been completed.

1.6 Attached is **Annexure A** of Injury on Duty reporting procedures and W.CI.2 form to be completed when employee suffers an injury at work.

Yours sincerely

Ms. D Moloi
CD: THRS
Date: 17/10/2023

OFFICE OF THE DIRECTOR: HRTS - HRA
Tel: (011) 843 6519 I Fax: (086) 594 6229 I P.O. Box 7710, Johannesburg 2000
26 Loveday Street, Johannesburg, 2001
Website: www.education.gpg.gov.za

COMPENSATION FUND'S INJURY ON DUTY REPORTING PROCEDURES

Employee

1. The employee has to report the accident to the employer as soon as possible after such accident has happened – Section 38 of the COID Act. If notice is not given to the employer/ Compensation Commissioner within 12 months after the date of accident the employee forfeits his right to compensation, as the claim cannot be considered in terms of the Act.

2. Should the employer fail to report the accident the employee has to complete a Notice of Accident and Claim for Compensation (W.Cl. 3).

3. The employee must assist the employer in obtaining the medical reports as the employee has chosen the doctor, sees the doctor regularly and it is his (the employee's) case that has to be finalised.

It is important that the employee must get involved and drive his/her case. He/she must not sit back and wait for other people to do it.

Employer

1. The employer has to report the accident in the prescribed manner – i.e. by completing the Employer's Report of an Accident (W.Cl. 2). The act requires that an accident be reported by the employer to the Compensation Commissioner within 7 days after the accident took place.

2. Part B of the Employer's Report of an Accident (W.Cl. 2) is a carbon copy of Part A and should be handed to the employee to give to the doctor/hospital/chiropractor who is going to treat him.

   If an employer fails to report the accident, the doctor can report the case by sending a copy of Part B to the Compensation Commissioner. The employer will then be subpoenaed to submit Part A.

3. Obtain First Medical Report (W.Cl. 4) from the treating doctor – medical evidence plays an important part when liability for the payment of compensation and medical expenses is considered.

4. Obtain Progress Medical Reports (W.Cl. 5) – when an employee is receiving prolonged medical treatment and is off duty as a result of injuries sustained in an accident, progress medical reports should be submitted on a monthly basis to the Compensation Fund to ensure that compensation in respect of temporary total disablement is paid timeously.

5. Final Medical Report (W.Cl. 5) – should be submitted as soon as the employee's condition has become stable. The doctor has to describe the impairment of function as a result of the accident, if any, to enable the Fund to assess permanent disablement, if any.

6. Resumption Report (W.Cl. 6) – the form has to be completed by the employer immediately after the employee has resumed work. Where an employee is booked off duty for a lengthy period, interim reports must be submitted.

7. Employee's banking details form should be submitted – should the claim qualify for any compensation, this form will be used to verify the claimant's banking details.

It is important that employers should not wait for full documentation before reporting an accident.

labour

Department:
Labour
REPUBLIC OF SOUTH AFRICA

Compensation Fund
WORKING FOR YOU

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Department:
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COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

Section 6(A) – Annexure 13

EMPLOYER'S REPORT OF AN ACCIDENT

(For official use only)

Claim No.: .....

Provincial Office

.....

Date .....

DIRECTIONS FOR COMPLETING OF FORM BY EMPLOYER

This form must be completed:

(1) Whenever an employee meets with an accident arising out of and in the course of his/her employment resulting a personal injury for which medical treatment is required, or death.

(2) Whenever an employee reports any personal injury to his/her employer, if in making the report the employee alleges that such injury arose out of land in the course of his/her employment.

(Where the accident has caused death, unconsciousness or amputation or where the injured employee is presumed unable to work for a period of at least 14 days, the Provincial Executive Manager of Labour must ALSO be notified by telephone or fax, without delay).

Step 1 Complete "Part A", page 1 of the form by giving full details, sign and date form where indicated.

Step 2 Detach "Part B" (an automatic copy of "Part A", page 1) by tearing it at the perforation, hand "Part B" to the employee and request him/her to hand it to the medical practitioner/chiropractor or the hospital concerned. **In serious cases "Part B" must be forwarded to the medical practitioner/chiropractor or the hospital without delay.**

Step 3 Complete "Part A", page 2 of the form by giving full details.

Step 4 **Forward the completed report of an accident together with a certified copy of the employee's ID and the First Medical Report (W.CI.4) (If available) to:**

THE COMPENSATION COMMISSIONER
COMPENSATION HOUSE
CNR. SOUTPANSBERG AND HAMILTON ROAD
P.O. BOX 955
PRETORIA
0001

Call Centre 086 010 5350
Fax (012) 323-8627
(012) 325-6686
(012) 326-7889
(012) 323-6986

e-mail • cf-info@labour.gov.za
Website • http://www.labour.gov.za

N.B.:

1) Complete a separate form in respect of each injured employee.
2) This form must be delayed in expectation of the employee resuming employment or awaiting medical reports.
3) An employer who fails to report any accident within 7 days to the Compensation Commissioner on this form, shall be guilty of an offence in terms of the Compensation for Occupational Injuries and Disease Act, 1993 and may held liable for the full amount of compensation payable in respect of such accident.
4) An employer who fails to report accidents that have caused death, unconsciousness or amputation or cases where the injured employee is presumed unable to work for a period of at least fourteen days to the Provincial Executive Manager of Labour by telephone or fax, shall be guilty of an offence in terms of the occupational Health and Safety Act, 1993.
5) Use the appropriate form or the reporting of occupational diseases. (W.CI.1).
6) If an injured employee should leave your employ, please keep record of the address where he/she can reached so that monies which might be payable to him/her from the Compensation Fund, can be sent to him/her with your assistance.
7) Minor injuries where no medical attention was required should not be reported, however a record should be kept of such injuries.

EMPLOYER'S REPORT OF AN ACCIDENT

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

Section 6(A) (b) – Annexure 13

Instructions:
Complete the form in block letters and mark appropriate areas (X)

(For official use only)
Claim No.: .....
Provincial Office
.....
Date .....

DECLARATION BY EMPLOYER OR AUTHORISED PERSON

I hereby declare that the particulars, shown in items 1 to 62 of this report, of an alleged injury on duty, are to the best of my knowledge and belief true and accurate.

Signed on this ..... day of .....year..... → **Signature** .....

EMPLOYER

1. Registered name with the Compensation Commissioner .....
2. Registered number of this business with the Compensation Commissioner
3. Contact person .....
4. Street address ..... 5. Postal code .....
6. Postal address ..... 7. Postal code ..... 8. Tel. no. (.....) .....
9.1 Fax no. (.....) ..... 10. Situation of business/farm .....
9.2 E-mail address .....
11. Nature of business, trade or industry .....

EMPLOYEE (CERTIFIED COPY OF IDENTITY DOCUMENT TO BE ATTACHED)

12. Is the injured person a | working director | working member of a CC | owner of | partner in the business? | Not applicable |
13. Surname ..... 14. First names .....
15. ID no. ..... 16. Date of birth ...../...../..... 17. Sex | Male | Female |
18. Marital state | Married | Single | 19. Citizen of .....
20. Personnel no. ..... 21. Occupation .....
22. Street address ..... 23. Postal code .....
24. Postal address ..... 25. Postal code .....
26. Tel. No. (.....) .....
27. Period in your employ (years/months) ...../..... 28. Expected period of disablement (days) | 0-13 days | 14 & more |

ACCIDENT

29. Date of accident ...../...../..... 30. Time .....
31. Place of accident ..... 32. District .....
32.2 Province .....
33. Date employee reported accident ...../...../..... 34. Time .....
35. What task was the employee performing at the time of the accident? .....
36. Period of experience in the task performed (years/months) ...../.....
37. Was his action at the time of the accident in connection with your trade or business? | YES | NO |
(If "no" state reasons on reverse side Part A page 3)
38. Short description of how the accident occurred. (**ALSO** mark the applicable items on the reverse side of Part A Page 3 and use same for a full description) .....
.....
(Refer the machine/process involved, whether the injured person fell or was struck and all the factors contributing to the accident).
39. Was the accident a traffic accident on a public road? | YES | NO |
40. Nature of injury sustained (e.g. index finger of right hand crushed) .....
Mark any of the following when applicable: | Killed | Amputation | Unconsciousness |
41. Are you satisfied that the employee was injured in the manner alleged by him? | YES | NO | If not, give reasons.
(If "no" state reasons on reverse side Part A page 3)
.....

PART A PAGE 2 MUST ALSO BE COMPLETED

Please complete in detail to ensure early finalisation.

(COMPULSORY TO COMPLETE)

PART A PAGE 2

Employer: ..... **Date of accident:** .....

Employee: ..... **Employee's ID No:** .....

FURTHER PARTICULARS OF EMPLOYEE

42. Earnings of employee at the time of accident:
Attach copy of payslip as at time of accident.

	R/Week	R/Month
Gross cash earnings: (Including average payments for overtime and/or commission of a constant character)		
Allowances of a recurrent nature:		
a) Bonuses (i.e. 13th cheque)		
b) Other allowances (specify nature)		
Cash value of:		
Free food		
Free quarters		
Other payment in kind (specify nature)		

43. In terms of section 47 of the Act an employer is obliged to pay an employee full compensation for the first three months of absence

44. Are you prepared to make further compensation payments after the first three months from the date of the accident? YES | NO

45. If you have already paid cash (earnings) to the employee, state the total amount R .....

46. For what period were such payments made? From ...../...../..... To ...../...../.....

47. Number of days per week worked by the employee .....

48. Date on which the employee ceased work due to accident ...../...../..... 49. Time .....

50. Did the employee complete his shift on the day that he ceased work? YES | NO

51. Date on which the employee resumed work ...../...../..... 52. Time .....

(If the employee will be off duty for an extended period, an interim Resumption Report (W.CI.6) must be submitted monthly).

53. If the employee was killed in the accident, state name and address of dependant of the employee. .....

.....

FURTHER PARTICULARS

54. Should the employee have any physical defect, have suffered from any serious disease prior to the accident or has previously received compensation for permanent disablement, give full particulars. .....

55. Was first aid given in this case? YES | NO

56. State the name of the medical practitioner/chiropractor who treated the employee. .....

57. If the employee received treatment at a hospital, state name of hospital. .....

58. Was the accident caused by the employee's: a) Deliberate non-compliance with 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 accidents? YES | NO

c) Action while under the influence of liquor or drugs? YES | NO

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

59. Name and address of anybody: a) Who witnessed the accident .....

b) Who was aware of the accident at the time .....

60. How many other employees were injured in the same accident? .....

61. If the accident was investigated by the SA Police, state name of Police Station and docket number applicable .....

.....

62. If motor vehicles were involved, furnish registration number/s. .....

ANY ADDITIONAL DETAILS CAN BE SUPPLIED ON PART A PAGE 3

Employer: ..... **Date of accident:** .....

Employee: ..... **Employee's ID No:** .....

38. Continuation of point 38 of the previous page. Contributing factors/causes applicable. (Mark the applicable item/s at A and B).

A)

Defective plant	
Defective machine	
Unfavourable conditions of work	
Fault of employer	
Fault of injured employee	
Fault of supervisor	

B)

Railway	
Building work	
Electricity	
Chemicals	
Poisoning	
Burns	

Explosions	
Rotating machine	
Press/Rollers	
Woodworking machine	
Lifting machine	
Hand tools	

Other machinery (Specify): .....

Any other contributing factors, not mentioned above (Specify): .....

The rest of this page may be used for any additional details or comments regarding the accident.

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EMPLOYER'S REPORT OF AN ACCIDENT

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

Section 6(A) (b) – Annexure 13

Instructions:
Complete the form in block letters and mark appropriate areas (X)

(For official use only)
Claim No.: .....
Provincial Office
.....
Date .....

DECLARATION BY EMPLOYER OR AUTHORISED PERSON

I hereby declare that the particulars, shown in items 1 to 62 of this report, of an alleged injury on duty, 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. Registered number of this business with the Compensation Commissioner
3. Contact person .....
4. Street address ..... 5. Postal code .....
6. Postal address ..... 7. Postal code ..... 8. Tel. no. (.....) .....
9.1 Fax no. (.....) ..... 10. Situation of business/farm .....
9.2 E-mail address .....
11. Nature of business, trade or industry .....

EMPLOYEE (CERTIFIED COPY OF IDENTITY DOCUMENT TO BE ATTACHED)

12. Is the injured person a | working director | working member of a CC | owner of | partner in the business? | Not applicable |
13. Surname ..... 14. First names .....
15. ID no. ..... 16. Date of birth ...../...../..... 17. Sex | Male | Female |
18. Marital state | Married | Single | 19. Citizen of .....
20. Personnel no. ..... 21. Occupation .....
22. Street address ..... 23. Postal code .....
24. Postal address ..... 25. Postal code .....
26. Tel. No. (.....) .....
27. Period in your employ (years/months) ...../..... 28. Expected period of disablement (days) | 0-13 days | 14 & more |

ACCIDENT

29. Date of accident ...../...../..... 30. Time .....
31. Place of accident ..... 32. District .....
32.2 Province .....
33. Date employee reported accident ...../...../..... 34. Time .....
35. What task was the employee performing at the time of the accident? .....
36. Period of experience in the task performed (years/months) ...../.....
37. Was his action at the time of the accident in connection with your trade or business? | YES | NO |
(If "no" state reasons on reverse side Part A page 3)
38. Short description of how the accident occurred. (**ALSO** mark the applicable items on the reverse side of Part A Page 3 and use same for a full description) .....
.....
(Refer the machine/process involved, whether the injured person fell or was struck and all the factors contributing to the accident).
39. Was the accident a traffic accident on a public road? | YES | NO |
40. Nature of injury sustained (e.g. index finger of right hand crushed) .....
Mark any of the following when applicable: | Killed | Amputation | Unconsciousness |
41. Are you satisfied that the employee was injured in the manner alleged by him? | YES | NO | If not, give reasons.
(If "no" state reasons on reverse side Part A page 3)
.....

PART A PAGE 2 MUST ALSO BE COMPLETED

Please complete in detail to ensure early finalisation.

PART B PAGE 2

DIRECTIONS TO MEDICAL PRACTITIONER/CHIROPRACTOR/HOSPITAL

(a) Only the Compensation Commissioner shall decide whether liability in respect of an accident should be accepted in terms of the provisions of the Act.

(b) If liability is not accepted by the Compensation Commissioner medical expenses cannot be paid from the Compensation Fund.

(c) The FIRST MEDICAL REPORT (W.CI.4) must be completed in ***duplicate*** and care must be taken to ensure that the full names of the employee and employer and the employee's ID number as shown on this form, appear thereon. The original must be sent to the employer as soon as possible whilst ***the duplicate must be kept by the medical practitioner/chiropractor or hospital together with this form.***

(d) The medical practitioner/chiropractor or hospital must send a specified account to the employer. if the account is still ***unpaid after 2 months this form together with the duplicate FIRST MEDICAL REPORT (W.CI.4)*** and specified account must be sent under cover of an ***Enquiry Regarding Unpaid Account (W.CI.20)*** to:

THE COMPENSATION COMMISSIONER
COMPENSATION HOUSE
CNR. SOUTPANSBERG AND HAMILTON ROAD
P.O. BOX 955
PRETORIA
0001

Call Centre 086 010 5350
Fax (012) 323-8627
(012) 325-6686
(012) 326-7889
(012) 323-6986

e-mail • cf-info@labour.gov.za
Website • http://www.labour.gov.za

PROVINCIAL OFFICES : DEPARTMENT OF LABOUR				
TOWN	POSTAL ADDRESS	STREET ADDRESS	TELEPHONE	FAX
Durban	PO Box 940	Salmon Grove Chambers 407 Smith Street	031 - 366 2191/00 031 - 366 2097/98	031 - 305 7560
Cape Town	PO Box 872	4th Floor Westbank House Cnr. Riebeeck and Long Street	021 - 441 8000	021 - 441 8048
Bloemfontein	PO Box 522	Laboria House 43 Maitland Street	051 - 505 6248 051 - 505 6200	051 - 447 9353
Kimberley	P/Bag X5012	Laboria House No. 43 Cnr. Compound & Pniel Roads	053 - 838 1500 053 - 838 1616	053 - 832 8167
Pretoria	PO Box 393	Concillium Building 239 Skinner Street	012 - 309 5282	012 - 309 5142
Johannesburg	PO Box 4560	Annuity House 18 Rissik Street	011 - 497 3086 011 - 497 3283 011 - 497 3136	011 - 497 3293
Mmabatho	P/Bag X2040	Provident House, 2nd Floor University Drive	018 - 387 8100	018 - 384 2597
Witbank	P/Bag X7263	Labour Building Cnr Hofmeyer & Beatty Avenue	013 - 655 8700	013 - 690 2622
Polokwane (Pietersburg)	P/Bag X9368	Boland Bank Building 42a Shoeman Street	015 - 290 1740	015 - 290 1692
East London	P/Bag X9005	Laboria Building Cnr Church & Oxford Streets	043 - 701 3297 043 - 701 3000	043 - 743 2047