EMPLOYEES COMPENSATION ACT, 1941 **CLAIM NO.** .....

RESUMPTION REPORT

This form must be completed and submitted by the employer **immediately** the employee resumes or if discharged by his employer, after such discharge.

Surname of injured employee	N.I.NO.
Christian Name(s)	Co. No.
Please use Block Letters	
Name of Employer	Date of Accident:
Address	
Postal Code:	

	FROM: DATE	FROM: TIME	TO: DATE	TO: TIME
1. State the period(s) the employee was off duty as a result of the accident. (PERIOD(S) OFF WORK)				
2. Did he resume work for any period subsequent to the accident but prior to the date of resumption given in item 3? If so, give rate of earnings and explain circumstances if back on (a) Light Duty (b) Normal Duty PERIOD(S) BACK AT WORK)				

3. When did the employee resume work with your permanently subsequent to the accident? .....

4. The employee left my services on ..... (date)

5. The employees present address is .....

6. Have you made any payments i.r.o. his earnings to him for the period(s) mentioned in paragraph 1 above? if so STATE AMOUNT

   N$ .....

7. Dit 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) herunder at paragraphs (a) and/or (b).

   (a) Food: Period From ..... to .....

   (b) Quarters: Period From ..... to .....

8. Period detained in hospital From ..... to .....

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EMPLOYER

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