Caring | Compassionate | Compensation

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										L	R	B		
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		Cell 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		

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

RMA Claim No:

EMPLOYEE DETAILS

Title (Mr; Mrs; Ms)		First Name/s	
Surname			
Employee Number		Industry No.	
ID/Passport No			
Accident Date	Y Y M M D D	Date of Birth	Y Y M M D D

ACCIDENT EARNINGS

PLEASE NOTE : *Non-variable earnings should be the earnings of the month prior to the accident date*

Non Variable Earnings	
Basic Salary	
Housing	
Annual Bonus	
Food	
Quarters	
Specify "Other"	
Specify "Other"	
Sub Total	

PLEASE NOTE:
- **Month 1** should be the earnings of the month prior to the accident
- **Month 6** should be earnings of the seventh month prior to the accident

Variable Earnings	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Underground Allowance							
Production Bonus							
Attendance Bonus							
Drilling Bonus							
Overtime							
Specify "Other"							
Specify "Other"							
Specify "Other"							
Specify "Other"							
Specify "Other"							
Specify "Other"							
Specify "Other"							
Total							
(÷6) Ave Variables							
+ Non Variables							
= Accident Earnings							

EMPLOYEE BANKING DETAILS

Bank		Branch Name	
Account No.			
Branch Code		Account Type	

DECLARATION BY EMPLOYER

I hereby declare that the employee's earnings and banking details are correct as at the time of the accident and that I am authorised to make this declaration. Should the employee suffer any financial loss due to the incorrect declaration of earnings and/or banking details, such loss(es) will be recoverable from the employer.

Name of authorised signatory		Signature	
Designation		Date	Y Y M M D D