DOSH 1

REPUBLIC OF KENYA

DIRECTORATE OF OCCUPATIONAL SAFETY AND HEALTH SERVICES

NOTICE BY EMPLOYER OF AN OCCUPATIONAL ACCIDENT/DISEASE OF AN EMPLOYEE

PART I

1. Employer Particulars:-
   - ii. Name .....
   - iii. Employers registration No.....
   - iv. Full Address .....
   - v. Industry or business.....
   - vi. Name and address of Insurance Company which has insured employee against accident

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2. The Injured/sick employee's particulars :-
   - i. Name.....
   - ii. Sex.....
   - iii. Age.....
   - iv. Occupation .....
   - v. Full Address.....
   - vi. E- Mail address.....Tel: .....
   - vii. Identity Card No. (or other Identity particulars).....

3. Occupational Accident
   - i. Date of Accident .....Time: .....Fatal /Non fatal .....
   - ii. Has the worker resumed working Yes/No ..... Date of resumption .....
   - iii. Place .....
   - iv. What is the injured worker's Occupation .....
   - v. Length of service with the present employer .....
   - vi. What work is the worker employed to undertake .....
   - vii. Cause of Injury .....
   - viii. Type of Injury .....
   - ix. Part of Body Injured .....

4. Occupational Disease

   Details about the Occupational disease affecting the employee.
   - i. Date of diagnosis the occupational disease .....
   - ii. Name of medical practitioner who made the diagnosis .....
   - iii. Date the employer was notified of the disease by the employee or medical practitioners.....
   - iv. Describe the Cause of the occupational disease .....

     .....

     .....

5. Monthly earning at the date of the Accident/disease:-

   Cash wage (exclusive of overtime, house e.t.c. the payment) .. .. .. Sh. .....

   Value of Rations.. .. .. Sh .....

   Value of Housing ... . Sh.....

   Value of fuel .. .. Sh.....

   Overtime payment of other special remuneration for work done whether by way of bonus otherwise if of constant character and for work habitually performed .. .. .. Sh. .....

   Total earning per month ... . Sh.....

Signature of Employer ..... Date .....

Designation .....

Note:- In the case of injury to a workman involving incapacity for work for three or more consecutive days, it is requested that the employer complete Part 1 in triplicate and then dispatch it immediately as under:

Original: - To the Occupational Safety and Health Officer.

Duplicate and Triplicate: - To the medical practitioner attending or examining the injured/sick employee.

In the case of an occupational accident/disease causing the death of an employee, Part 1 should be completed in duplicate and then dispatched immediately as under:

Original and duplicate: - To the Occupational Safety and Health Officer in charge of the District in which the accident occurred.

PART II

MEDICAL REPORT

(for use by the medical practitioner)

Name of employee .....

Date admitted to hospital..... Discharged.....

In-patient No. .....

Attendance as out-patient from..... to.....

Out –patient No. .....

Occupational disease .....

Is there permanent incapacity?.....*Yes/No.....

If yes please give:

a) Details and nature of permanent incapacity.....

.....

.....

.....

b) Percentage of permanent incapacity to be indicated in both words and figures.....

.....

.....

.....per cent.

Temporary incapacity :-(Likely duration of absence from work, from date of acquiring disease/or diagnosis etc.).....

....weeks/ months*

Is a further examination required before final assessment of permanent incapacity can be given?.....If yes ;

a) which ones ....

.....

b) when?.....

Name of medical Practitioner.....

Signature .....Date .....

Name of Hospital/Clinic/Private Practice.....

Note:- It is requested that this part be completed by the medical practitioner in duplicate, the form then being dispatched as under:

1. One copy to the employer.
2. One copy to the Occupational Safety and Health Officer in charge of the district in which the accident occurred

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PART III

(For use by Occupational Safety and Health Officer)

Compensation *is / is not being claimed on behalf of the employee/dependants of the deceased employee.

District and Accident Register No.....

Station..... Date.....

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Occupational Safety and Health Officer