DOSH 1

REPUBLIC OF KENYA

DIRECTORATE OF OCCUPATIONAL SAFETY AND HEALTH SERVICES

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

PART 1

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

     .....

     .....

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).....

Occupational Accident

- i. Date of Accident ..... Time: .....Fatal /Non fatal .....
- ii. Has the worker resumed working Yes/No .....Date of resumption .....
- iii. Place where accident took 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.....

Occupational Disease

3. Detail 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.....

   Allowances paid regularly .. .. .. Sh.....

   Overtime payment or/and 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.....

Name of Employer or person notifying on behalf of Employer .....Signature .....

Designation ..... Date .....

Note:-

1. **Ensure you enclose** a letter detailing any payment forming part of the employee's total earning that the employee has been paid during the period of temporary disablement when he/she was out of work as a result of the injury.
2. 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 quadruplicate and then dispatch the forms immediately as under:
   Triplicate: - To the Occupational Health and Safety Officer in charge of the District in which the accident occurred.
   Original and duplicate and quadruplicate: - To the medical practitioner attending or examining the injured/sick employee.
   The forms to be forwarded to the Occupational Health and Safety Officer immediately the doctor completes part ll
   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 , triplicate and quadruplicate: to the Occupational Health and Safety Officer in charge of the District in which the accident occurred

duplicate To be dispatched together with the death certificate to the Occupational Health and Safety Officer in charge of the District in which the accident occurred

PART 11 ((for use by the medical practitioner)

MEDICAL REPORT

Name of employee.....

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

In-patient No. .....

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

Out –patient No. .....

Type of injury.....or

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(***reference must be made to the first and second schedule of the Work Injury Benefit Act No. 13 of 2007***).....
.....
.....
.....per cent.

Temporary incapacity :-(Duration of absence from work, from the date of receiving injury or acquiring occupational disease/or diagnosis of occupational disease .)..... .....working days

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 Health and Safety Officer in charge of the district in which the accident occurred

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PART 111

(For use by Occupational Health and Safety Officer)

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

District and Accident Register No.....

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

....

Occupational Health and Safety Officer

GPK(L)

DOSH/WIBA 4

REPUBLIC OF KENYA

Claim Reference No .....

.....Occupational Health and Safety Services,
P.O. Box .....
.....
....., 20.....

.....
.....
.....

DEAR SIR/MADAM,

THE WORK INJURY BENEFITS ACT NO. 13 OF 2007
(* Section(s) 28/30/32/34)

RE: DEMAND FOR PAYMENT OF WORK INJURY BENEFIT

With Reference to the accident that occurred on .....to .....
....employed by you as ..... compensation payable to the employee is assessed at Ksh. ...., calculated as follows:-
(a) In respect of .....per cent permanent disablement (from details given on Form DOSH 1, Parts I and II):-

.....[1]per cent of 96 months' total earnings:

Ksh. .....(Monthly Total Earning) **X** 96 months X .....% Disablement
---------- = Ksh. .....
100

(b) In respect of temporary disablement (from details given on Form DOSH 1, Parts 1 and 11) , and your letter giving details of any payment made during period of disablement (Ref. .....Dated .....):-

Difference between monthly earnings at time of accident and earnings subsequent to accident:
For period .....to,,,,,,,,,,,,,,,,,,,,,,,,, at Ksh.....per month= Ksh.....
For period .....to,,,,,,,,,,,,,,,,,,,,,,,,, at Ksh.....per month= Ksh.....
For period .....to,,,,,,,,,,,,,,,,,,,,,,,,, at Ksh.....per month= Ksh.....

If you are in agreement with the above assessment done in accordance with section ..... of the Act, will you please sign the attached four (4) copies of Form DOSH/WIBA *5A/B(Agreement as to work injury benefit to be paid by the employer to the injured employee/Deceased employee's dependants) and send them to this office together with the *EMPLOYEE/DEPENDANTS concerned and your remittance of KSh. .... Cheques should be made payable to the injured employee .....
or dependant(s)[2] of the deceased employee .....
who have been identified by the District Commissioner as follows(**For minors see overleaf**)

1. .....Ksh.....
2. .....Ksh.....
3. .....Ksh.....
4. .....Ksh.....

Yours faithfully,

Official Rubber Stamp

Name.....Signature.....Date.....
Designation: .....

**Delete appropriately*

Note:

1. Percentage of disablement

2. For dependants who are minors, see below

PAYMENT OF WORK INJURY BENEFIT DUE TO A MINOR

The following dependants have been identified as MINORS under the age of 18 years old and the payment cheque should be drawn in the name of the person or institution indicated herein.

Dependant's Name	Age	The name of the person or institution under which the cheque for Work Injury Benefit payment due to him/her should be drawn
1.	.....	.....
2.	.....	.....
3.	.....	.....
4.	.....	.....
5.	.....	.....
6.	.....	.....
7.	.....	.....
8.	.....	.....