REGULATION 9 OF THE GENERAL ADMINISTRATIVE REGULATIONS  
RECORDING AND INVESTIGATION OF INCIDENTS

OCCUPATIONAL HEALTH AND SAFETY ACT, 1993   
(ACT NO. 85 OF 1993)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| A.  RECORDING OF INCIDENT | | | | | |
| 1. Name of employer | | | | | |
|  | | | | | |
| 2. Name of affected person | | | | | |
| 3. Identity number of affected person | | | | | |
| 4. Date of incident 5. Time of incident | | | | | |
| 6. Part of body affected | Head or neck | Eye | Trunk | Finger | Hand |
|  | Arm | Foot | Leg | Internal | Multiple |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 7. Effect on person | Sprains or strains | Contusion or wounds | Fractures | Burns | Amputation |
|  | Electric shock | Asphyxiation | Unconsciousness | Poisoning | Occupational Disease |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 8. Expected period of disablement | 0 – 13 days | 2 – 4 weeks | >4 – 16 weeks | >16 – 52 weeks | >52 weeks or permanent disablement | Killed |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 9. Description of occupational disease | | | | |
| 10. Machine/process involved/type of work performed/exposure\*\* | | | | |
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|  | | | | |
| 11. Was the incident reported to the Compensation Commissioner and the Provincial Director? | | | | |
|  |  | Yes | No |  |
| 12. Was the incident reported to the police?\* | | | | |
|  |  | Yes | No |  |
| 13. SAPS office and reference | | | | |
| \* to be completed in case of a fatal incident. | | | | |
| \*\* in case of a hazardous chemical substance, indicate substance exposed to | | | | |

|  |  |  |
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| B.  INVESTIGATION OF THE ABOVE INCIDENT BY A PERSON DESIGNATED THERETO | | |
| 1. Name of investigator | | |
| 2. Date of investigation | | |
| 3. Designation of investigator | | |
| 4. Short description of incident | | |
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|  | | |
|  | | |
| 5. Suspected cause of incident | | |
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|  | | |
|  | | |
| 6. Recommended steps to prevent a recurrence | | |
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|  | | |
|  |  |  |
| *Signature of investigator* |  | *Date* |

|  |  |  |
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| C.  ACTION TAKEN BY EMPLOYER TO PREVENT THE RECURRENCE OF A SIMILAR INCIDENT | | |
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| *Signature of* *employer* |  | *Date* |

|  |  |
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| D.  REMARKS BY HEALTH ANDSAFETY COMMITTEE | |
| Remarks | |
|  | |
|  |  |
| *Signature of Chairman of Health and Safety Committee* | *Date* |