FORM 24 (SEE RULE 115)

Report of accident by the Manager

1. Name and address of occupier
2. Occupier's Registration No. / Licence No.
3. Address of premises where accident happened
4. Natural of Industry.
5. Department, shift hours(if any) and exact place where the accident happened
6. Name of injured person.
7. Insurance Number.
8. Address of injured person
9. (a) Sex

   (b) Age (last birthday)

   (c) Occupation of injured person

   (d) Local office to which attached
10. Date and hour of accident
11. (a) Hour at which he started work on the day of accident

    (b) Whether wages in full or part are payable to him for the day of his accident
12. Cause of accident, -
    - If caused by machinery –
        a. Give name of the machine and part causing the accident, and
        b. State whether it was moved by mechanical power at that time;
    - State exactly what the injured person was doing at that time,
    - In your opinion, was the injured person at the time of accident -
        a. Acting in contravention of the provisions of any law applicable to him; or
        b. Acting in contravention of any orders given by or on behalf of occupiers; or
        c. Acting without instruction from his occupier,

- If reply to clauses (i), (ii) or (iii) of clause (c) is in affirmative, state whether the act was done for the purpose of and in connection with the occupier's trade or business.

13. If the accident happened while traveling by availing of the transport facility provided by the occupier, state whether –
    - The injured person was traveling as a passenger to or from his place of work;
    - The injured person was traveling with the express or implied permission of the occupier;
    - The transport is being operated or on behalf of the occupier or some other person by whom it is provided in pursuance of arrangements made with the occupier; and
    - The vehicle was being / operated in the ordinary course of public transport service.
14. If the accident happened while meeting emergency state –
    - Its nature;
    - Whether the injured person at the time of accident was employed for the purpose of his occupier's trade or business in or about the premises at which the accident took place.
15. Describe briefly how the accident occurred.
16. Name and address of witness –
    -
    -
17. (a) Nature and extent of injury (e.g., fatal, loss of fingers, fracture of leg, scald, etc).

    (b) Location of injury (Right leg, left hand or left eye, etc).

    (c) (i) if the accident is nor fatal, state whether the injured person has returned to work

    (ii) If so, date and hour of return to work.

18. (a) Physician, dispensary or hospital form whom or where the injured person received or is receiving treatment.

(b) Name of dispensary / panel doctor elected by the insured person.

19. (i) Has injured person died?

(ii) If so, date of death.

I certificate that to the best of my knowledge and belief the above particulars are correct in every respect.

Place: ………….. Signature …………………………..

Date of dispatch of report Designation ………………………..

Note. – To be completed in legible hand writing or preferably typewritten.

This space to be completed by Inspector of Factories.

District ………………………………

Date of Receipt of report …………….

Accident number ……………………

Industry number ……………………..

Causation number ……………………

Date of investigation ………………….

Result of investigation ………………..