THE FEDERATED EMPLOYERS' MUTUAL ASSURANCE COMPANY (RF) (PTY) LTD

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COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 AS AMENDED
RESUMPTION REPORT

N.B. This report must be completed and submitted by the employer immediately after the employee has resumed work or was discharged. If on prolonged treatment monthly resumption reports must be submitted until such time the employee is discharges or returns to work.

EMPLOYEE DETAILS

Claim Number:	**Date of Accident:**	**Staff Number:**
Name of Employer:		
Name of Employee:		

TO BE COMPLETED BY THE HR/WAGES/SALARIES DEPARTMENT

State the period(s) the employee was off duty or performing light duty	From		To		Advances/ Salary paid to the employee for the periods indicated as item 1
	Date	Time	Date	Time	
1. PERIOD(S) OFF DUTY					
2. PERIOD(S) PERFORMING LIGHT DUTY					

3. Was light duty available and offered to the employee? YES / NO .....

4. Did the employee perform **recommended** light duty? YES / NO .....(if not give reason)

.....

5. **If yes**, please provide us with the difference between the normal rate and the light duty rate.

indicate the rate of earnings paid whilst performing light duty? .....

6. Is the employee still in your employment? YES / NO .....(a) Left service on (date).....

(b) The employee's present address is .....

7. Confirm if the employer is prepared to pay beyond 3 months period. YES/NO.....

DECLARATION	
I hereby declare that the information furnished in this report is true and correct according to my knowledge.	
Initial and Surname:	Designation
E-mail:	Tel:
Signature	Date: