TWENTY-FIFTH SCHEDULE
[Section 86]

NOTIFICATION OF OCCUPATIONAL DISEASE BY OCCUPATIONAL HEALTH PHYSICIAN / EMPLOYER

Name of Occupational Health Physician/employer* .....

……

……

Address ....

……

National Identity Card no. .....

Business Registration no. .....

Contact details

(1) Office

Telephone no. ..... Mobile no. .....

Email address ..... Fax no. .....

(2) Residence

Telephone no. ..... Mobile no. .....

Nature of business .....…….....

Details of contact person

Name .....

Designation .....

Address ....

……..

National Identity Card no. .....

Telephone no. ..... Mobile no. .....

Email address ..... Fax no. .....

Name of the injured person(s)/deceased .....

……

National Identity Card no. .....

Contact details of employee suffering from disease

(1) Office

Telephone no. ..... Mobile no. .....

Email address ..... Fax no. .....

(2) Residence

Telephone no. ..... Mobile no. .....

Nature of disease (please attach medical certificate) …….....……

Contact details of next of kin of deceased

(1) Office

Telephone no. ..... Mobile no. .....

Email address ..... Fax no. .....

(2) Residence

Telephone no. ..... Mobile no. .....

Nature of disease (please attach medical certificate) …….....……

……

Name of employer.....……

……

Address .....

……

Business Registration no. .....

Contact details

(1) Office

Telephone no. ..... Mobile no. .....

Email address ..... Fax no. .....

(2) Residence

Telephone no. ..... Mobile no. .....

Nature of business …….....……

Date and place of accident .....

Any further particulars …….....…….....

…….

…….

I certify that to the best of my knowledge the information given above is correct.

…….. ……....
Name of Occupational Health Physician/employer* Signature

…….. ……....
Date Office stamp

* *Delete as appropriate*