



Occupational Safety and Health Division

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Notice of Accident by Injured Employee / Employee's Dependent

This form may take you 10 minutes to complete.
You will need the following information to fill in the form:

- Particulars of Injured/Deceased Employee
 - including salary vouchers
 - employment contract (if any)
- Particulars of Employer
- Details of the Accident
- Particulars of the Witness (if any)
- Copies of Medical Certificates/Appointment Card

**NOTICE OF ACCIDENT BY INJURED EMPLOYEE / EMPLOYEE'S DEPENDANT
MADE TO MINISTRY OF MANPOWER**

Report filed by: _____

Date of Report: _____

I Particulars of Injured / Deceased Employee	
Name:	NRIC / FIN / WP No.:
Mailing / Home Address:	
Tel No.:	Date of Birth:
Sex: M / F	Average Monthly Earnings ¹ :
Occupation:	Date of Commencement of Employment:
Brief Description of Job Duties:	
Work Pattern: 5-day week / 5.5-day week / 6-day week / Others (<i>please specify</i>) _____	

¹ Under the Work Injury Compensation Act, the "earnings" of an employee include his wages, food allowance, housing allowance, overtime, bonus or annual wage supplement but do not include travelling allowance, CPF contribution or pension or money paid to cover any special expenses incurred by him by nature of his employment; and

Where the employee has been employed for less than one month, his monthly earnings would be the earnings he would have received for the whole month; or

Where the employee has been employed for at least one month and for a continuous period of 12 months or shorter, his monthly earnings would be the average amount of his earnings during those 12 months or shorter period.

II Particulars of Employer	
Name of Company:	
Contact Person:	
Office Address:	
Tel No.: (Off) (Fax) (HP)	
III Details of Accident	
Date of Accident:	Time of Accident:
Place of Accident:	
Occupier In Charge (If applicable):	
Nature of Injuries:	
Description of Accident:	
Name of Hospital / Clinic Visited for treatment:	Is Injured Employee Still in Hospital: Yes / No
*No. of Days Medical Leave:	Is Injured Employee Back to Work? Yes / No
Was the Accident Reported to Employer? Yes / No	
If Yes, please specify the particulars (name, designation, employment) of whom the employee had reported to: _____	
If No, please specify reasons for not doing so: _____	

** Please furnish copies of the injured employee's medical certificates / bills for our reference*

Note:

For Section IV, please furnish the particulars of any witness(es) to the accident. Please note that if this section is not completed, the Ministry of Manpower will assume that there is no witness to the accident. If there were more witnesses, please provide particulars in separate attachments.

IV Particulars of Witness 1 to the Accident	
Name:	NRIC / FIN / WP No.:
Contact Address:	Employment:
Tel No.: (Off)	(Fax) (HP)
Sex: M / F	Occupation:
Please specify whether this witness: <input type="checkbox"/> Had seen the accident <input type="checkbox"/> Was nearby and came to the injured employee after the accident had happened <input type="checkbox"/> Was only informed about the accident by the injured employee after the accident	

Particulars of Witness 2 to the Accident	
Name:	NRIC / FIN / WP No.:
Contact Address:	Employment:
Tel No.: (Off)	(Fax) (HP)
Sex: M / F	Occupation:
Please specify whether this witness: <input type="checkbox"/> Had seen the accident <input type="checkbox"/> Was nearby and came to the injured employee after the accident had happened <input type="checkbox"/> Was only informed about the accident by the injured employee after the accident	

Note:

Section V is to be completed if this Report of Accident is filed by the dependant or co-worker, or person other than the injured employee.

V Particulars of Person Reporting the Accident	
Name:	NRIC / FIN / WP No.:
Contact Address:	
Tel No.: (Off)	(Fax) (HP)
Relationship with injured / deceased employee:	

I declare that the information I give for this claim is true and correct.

Signature of Injured Employee /
Dependant
Date

Name and Signature of Interpreter/
Date

Signature of Person Reporting
the Accident / Date

VI Additional details to be furnished if accident report is filed by injured employee:

1) Did you go to the medical institution alone or did somebody accompany you? If somebody had accompanied you, please provide the name, telephone number and address of this person.

2) Were you admitted for observation / treatment or just given medical leave and for how many days?

3) Did you seek medical attention immediately after your accident? If no, please specify your reasons for not doing so and the exact date on which you had first visited a medical institution after your accident.

4) Were you referred to any other medical institution for follow up treatment? If yes, please specify:

5) Did you tell your company that you were going to seek medical treatment/medical reviews? If yes, please give name, position and contact number of person you informed.

6) Are you still currently attending medical reviews? If yes, please advise which medical institution you are visiting. _____

7) Have you submitted the original medical certificates and bills to your employer? If yes, please advise who did you submit the documents to (name, position and contact number).

8) Has your employer paid you for the medical leave wages and medical expenses?

9) Do you suffer from any underlying medical condition? If yes, please specify your condition and advise when you first knew about this condition. Which medical institution had diagnosed your condition and does your company know about your medical condition?

I declare that the information I give for this claim is true and correct.

Signature of Injured Employee /
Dependant
Date

Name and Signature of Interpreter/
Date