

Republic of the Philippines
Department of Labor and Employment
BUREAU OF WORKING CONDITIONS
Manila

EMPLOYER'S WORK ACCIDENT ILLNESS REPORT

(This Report shall be submitted by the employer for every accident or illness to the Regional Office having jurisdiction on or before the 20th day of the month following the date of the accident)

	1.	ESTABLISHMENT	_____
	2.	ADDRESS	_____
EMPLOYER	3.	NAME OF EMPLOYER	_____ NATURE OF BUSINESS _____
	4.	NUMBER OF EMPLOYEES: MALE	_____ FEMALE _____ TOTAL _____
INJURED OR ILL PERSON	5.	NAME	_____ AGE _____ SEX _____ CIVIL STATUS _____
	6.	ADDRESS	_____
	7.	AVERAGE WEEKLY WAGE	_____
	8.	LENGTH OF SERVICE PRIOR TO ACCIDENT OR ILLNESS	_____
	9.	OCCUPATION	_____ EXPERIENCE AT OCCUPATION _____
	10.	WORK SHIFT	_____ 1ST _____ 2ND _____ 3RD HOURS OF WORK/DAY _____ WEEK _____
	11.	DATE OF ACCIDENT/ILLNESS	_____ TIME _____
ACCIDENT OR ILLNESS	12.	THE ACCIDENT INVOLVED PERSONAL INJURY	_____ PROPERTY DAMAGE _____
	13.	DESCRIPTION OF ACCIDENT OR/ILLNESS GIVE FULL DETAILS ON HOW A ACCIDENT/ILLNESS OCCURRED	_____
	14.	WAS INJURED DOING REGULAR PART OF JOB AT THE TIME OF ACCIDENT OR ILLNESS? IF NOT WHY?	_____
NATURE AND EXTENT OF INJURY OR ILLNESS	15.	EXTENT OF DISABILITY	_____ FATAL _____ PERMANENT TOTAL _____ PERMANENT PARTIAL _____ TEMPORARY TOTAL _____ MEDICAL TREATMENT _____
	16.	NATURE OF INJURY OR ILLNESS	_____ PART OF THE BODY AFFECTED _____
	17.	DATE DISABILITY BEGAN	_____ DATE RETURNED TO WORK _____
	18.	DAYS LOST	_____ OR DAYS CHARGE _____
CAUSE OF ACCIDENT OR ILLNESS	19.	HE AGENCY INVOLVED	_____
	20.	THE AGENCY PART INVOLVED	_____
	21.	ACCIDENT TYPE	_____
	22.	UNSAFE MECHANICAL OR PHYSICAL CONDITION	_____
	23.	UNSAFE ACT	_____
	24.	CONTRIBUTING FACTOR	_____
	25.	PEVENTIVE MEASURES (TAKEN OR RECOMMENDED)	_____
PREVENTIVE MEASURES	26.	MECHANICAL PERONAL PROTECTIVE EQUIPMENT AND OTHER SAFEGUARD	_____
	27.	WERE ALL SAFE GUARD IN USE? IF NOT WHY?	_____
	28.	COMPENSATION	_____
MANPOWER	29 & 30.	MEDICAL & HOSPITALIZATION.	_____ BURIAL _____
	31.	TIME LOST ON DAY OF INJURY. . . HOURS	_____ MINUTES _____
	32.	TIME LOST ON SUBSEQUENT DAYS, HOURS (LOST TREATMENT OR OTHER REASON)	_____ MINUTES _____
	33.	TIME ON LIGHT WORK OR REDUCED OUTPUT-DAY	_____ PERCENT OUTPUT _____
MACHINERY AND TOOLS	34.	DAMAGE OF MACHINERY AND TOOLS (DESCRIBED)	_____
	35.	COST OF REPAIR OR REPLACEMENT.	P _____
	36.	LOST OF PRODUCTION TIME	_____ COST P _____
	37.	DAMAGE TO MATERIALS (DESCRIBED)	_____
MATERIALS	38.	COST OF REPAIR OR REPLACEMENT..	P _____
	39.	LOST OF PRODUCTION TIME	_____ COST P _____
	40.	DAMAGE TO EQUIPMENT (DESCRIBED)	_____
EQUIPMENT	41.	COST OF REPAIR OR REPLACEMENT.	P _____
	42.	LOST PRODUCTION ON TIME	_____ COST P _____

I HEREBY CERTIFY on my honor to the accuracy of the foregoing information

DATE

Investigating Officer & Position

EMPLOYER