CLAIM NUMBER:	**ASSAULT REPORT QUESTIONNAIRE**	STAFF NUMBER:
EMPLOYER:	DATE OF INJURY:	EMPLOYEE NAME:

Details of the incident to be submitted and limited only to personnel who has a legitimate need to know.

DETAILED DESCRIPTION OF THE INCIDENT:	
TIME OF INCIDENT:	PLACE OF INCIDENT:

WAS THE CASE REPORTED TO SAPS? YES ☐ NO ☐ IF YES PLEASE PROVIDE THE FOLLOWING:

NAME AND CASE NUMBER _____

WAS THE EMPLOYEE OFFICIALLY ON DUTY AT THE TIME OF THE INCIDENT? YES ☐ NO ☐

WAS THE INCIDENT WORK RELATED? YES ☐ NO ☐

IF "NO" PLEASE EXPLAIN _____

_____

WAS THE INJURED EMPLOYEE THE PROVOKER? YES ☐ NO ☐

PLEASE SUPPLY THE FOLLOWING STATEMENTS AND CONTACT DETAILS FROM:

(A) AN EYEWITNESS
(B) THE EMPLOYEE
(C) COPY OF DISCIPLINARY ACTION IF ANY

SIGNATURE OF EMPLOYER:	**DATE SIGNED:**

THE INFORMATION IN THIS REPORT IS REQUESTED BY THE WORKMANS COMPENSATION COMMISSIONER TO ENABLE THEM TO ASCERTAIN LIABILITY FOR PAYMENT OF COMPENSATION AND MEDICAL EXPENSES. KINDLY RETURN THE COMPLETED QUESTIONNAIRE BY FAX TO IOD SOLUTIONS FAX NO: 086 513 9717 AT YOUR EARLIEST CONVENIENCE. SHOULD YOU REQUIRE ANY FURTHER INFORMATION, PLEASE CONTACT IOD SOLUTIONS ON TEL NO: 041 360 3417.

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