TRAVEL REPORT QUESTIONNAIRE

NAME	Date of injury	Employer

1. Describe in detail how and where (street names, etc) the accident happened, stating the time of the accident: *(Please include detailed statements by the driver of the vehicle and eyewitnesses to the accident, describing how and where the accident occurred, as well as a diagram.)*

2. Who is the registered owner of the vehicle?

3. Route Traveled:		4. Purpose of the journey (Pls mark with "X")	
From:		Business	
To:		Private	

5. Was the vehicle traveling on a direct route to its destination from its place of departure?

6. Was the vehicle specifically used for the purpose described in your answer in question 4? (For example, if the purpose of the journey was to deliver bread, was the vehicle assigned to the task of transporting bread?)

7. What control did you exercise over the driver of the vehicle for determining the vehicle's point and time of departure, destination and route, as well as being able to discontinue the transport at any time?

8. Was transport supplied free of charge to the employees to transport them to and from work? (Only applicable if transport was to or from work.)

9. Name and details of driver's Employer:	10. Person responsible for trip and cost thereof:
11. Who is the registered owner of the vehicle?	12. Registration No of vehicle(s) involved in Accident:
13. S.A.P. Branch where Accident was reported	14. S.A.P. Case No:

15. Details of other injured employees, if any:

Name and Surname	Claim number

Employer's Signature		Date signed	

THE INFORMATION IN THIS REPORT IS REQUESTED BY THE COMPENSATION FUND TO ENABLE THEM TO ASCERTAIN LIABILITY FOR PAYMENT OF COMPENSATION AND MEDICAL EXPENSES FOR THE ACCIDENT INVOLVING THE ABOVE NAMED EMPLOYEE. 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.