GOVERNMENT NOTICE No. 779 Published On. 5/11/2021

THE WORKERS COMPENSATION ACT,
(CAP. 263)

NOTICE

(Made under section 7(l)(c))

THE WORKERS COMPENSATION (COMPENSATION FORMS) NOTICE, 2021

Citation

1. This Notice may be cited as the Workers Compensation (Compensation Forms) Notice, 2021.

Notice

Cap. 263

2. Notice is hereby given that the Forms WCP-2 and WCP-3 set out in the Schedule to this Notice shall be used in compensation claims for the purposes of the Workers Compensation Act.

SCHEDULE

(Made under paragraph 2)

WCP-2

WORKERS COMPENSATION FUND

MEDICAL SERVICES CLAIM FORM

A. Patient information

Names of Patient (Full Name) ....

Age ..... Sex ..... ID No ..... Mobile No .....

Employer's Name.....

Treatment File No. .....

B. Health facility (Hospital/Health Centre/Dispensary/Clinic)

Name of health facility……..

. Address of facility.....Region .....District.....

C. Medical information

Nature of illness/injury (Mark (V) appropriately)

Occupational Accident		Occupational Disease	

Diagnosis…… date of diagnosis... ... .

Is the condition recurrent or chronic ……

Are the any underlying conditions whish could result in this illness or Injury (yes or no, if yes specify)

……..

D. Break down of expenses

Consultation Fee .... Admission Cost

..... No of days .....

INVESTGA TION	INVESTGA TION	INVESTGA TION	INVESTGA TION	INVESTGA TION

TOTAL				

PROCEDURES	PROCEDURES	PROCEDURES	PROCEDURES
TOTAL			

GRAND TOTAL: .....· .....

E. Certificate by medical practitioner

I certify that the above information is true, to the best of my knowledge and the medical expenses incurred were as a result of the illness/injury referred to.

Prescriber's names (full name) ....

Designation .....

Qualification .....Signature .. ..Date .....

Official stamp ....

F. Patient Certification:

I certify to get the above mentioned Investigation(s) is/were performed as confirmed by my signature hereunder

Signature…….. Date……

WCP-3

WORKERS COMPENSATION FUND

MEDICAL PROGRESS REPORT FORM

(This form shall be filled by a Medical Practitioner)

A. Employee/Patient identification

Medical File No.	Name of the patient	Sex	Date of Birth

B. Name and address of health care provider

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C. Type of medical progress (Mark(../) appropriately)

Hospitalized		Scheduled visit		Others (specify)	

D. Medical care services details

Date of ca (DD/MM/Y	Diagnosis	Condition of the patient (major clinical findings from history, physical examination and tests)	Summary description of health care services (type of consultation, medications, medical tests, procedures etc.)	Date of vi (DD/MM/Y	Additiona Duty Exemptio Days (i.e., ED and/orLD)

Medical Practitioner's Remarks

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GN. NO. 779 (Contd.)

DECLARATION

I declare that what I have stated herein above is true to the best of my knowledge.

Name of medical practitioner ..... Designation .....

Registration No .....Cell phone……E-mail .....

Signature ..... Date ..... (DD/MM/YY)

Official Stamp

Dar es Salaam,
25th October, 2021

JOHN K. MDUMA,
Director general