

CLAIM NUMBER

**COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES
ACT, 1993**

(Previously Workmen's Compensation Act, 1941)

STRAIN OR SPRAIN QUESTIONNAIRE
(Must be completed by the employee)

Employee : Date of accident :

Employer :

1. What were you busy doing immediately before you felt the pain? (Please give a detailed description)

.....
.....
.....
.....
.....
.....

2. Was this your normal work?

.....

3. Describe in detail what happened and how the injury or inconvenience was caused:

.....
.....
.....
.....
.....
.....

4. If you handled a heavy object, what was it's mass (weight)?

5. Did you receive assistance from anyone with this work?

.....

6. When did you report the injury to your employer?

7. To whom of your fellow workers did you first mention the injury?

.....
Date:

.....
Signature of employee