REPUBLIC OF NAMIBIA
SOCIAL SECURITY COMMISSION
EMPLOYEES COMPENSATION ACT, 1941

E.CL.6

RESUMPTION REPORT

This form must be completed and submitted by the employer immediately the employee resumes or if discharged by his/her employer, after such discharge.

Surname of Injured Employee	N.I.N.O.
Full Names	Co. No.
PLEASE USE BLOCK LETTERS	
Name of Employer	Date of Accident
Address	
Postal Code	

	FROM		**TO**	
	DATE	**TIME**	**DATE**	**TIME**
1. State the period(s) the employee was off duty as a result of the accident. (PERIOD(S) OFF WORK)				
2. Did he/she resume work for any period subsequent to the accident but prior to the date of resumption given in item 3? If so, give rate of earnings and explain circumstances if back on.				
(a) Light Duty				
(b) Normal Duty PERIOD(S) BACK AT WORK				

3. When did the employee resume work with your permanently subsequent to the accident? ……..…….

4. The employee left my services on ……..……...(date)

5. The employee's present address is ……..……...

6. Have you made any payments i.r.o. his earnings to him/her for the period(s) mentioned in paragraph 1 above? If so, state the AMOUNT

N$ ……..

7. Did the employee receive free food and/or quarters from you during the period(s) mentioned in paragraph 1 above? If so, state the period(s) hereunder at the paragraphs (a) and/or (b).

(a) Food Period From ……. To ……..

(b) Quarters Period From ……. To ……..

8. Period detained in hospital From ……. To ……..

I hereby declare that the particulars in the foregoing report are true and correct.

……

EMPLOYER

Date ……