Work Accident Notification Form

Occupational Safety & Health
Department, Labour Affairs Bureau
Tel no.：83999438
Fax no：28717771
E-mail：o.injury@dsal.gov.mo

Injured Details

Name:(Chinese) _____ (Foreign) _____

Date of Birth: _____/_____/_____ (dd/mm/yyyy) Gender: ☐ Male ☐ Female Place of Origin:_____

☐ Resident ☐ Non-resident I.D Type：_____ I.D. No.:_____

Address: _____

Local Mobile: _____ Other Contact No.: _____

Position: _____ Hiring Date: (Day)_____ (Month) _____ (Year) _____

Latest 3 Months Salary: $_____/ $_____/ $_____

Employer Details

Name of Employer: _____

Name of Company: _____ Name of Person-In-Charge: _____

Address: _____

Phone No.: _____ Fax No.: _____ E-mail: _____

Submitter / Contact Person: _____ Submitter /Contact No.: _____

Accident Details

Place of Accident: _____

Date of Accident: _____/_____/_____ (dd/mm/yyyy) Time of Accident: _____:_____

Accident Occurred: ☐ During Working Hours ☐ On the Way to Work ☐ Leaving Work

Brief Description of Accident:

Medical Treatment: ☐ Yes ☐ No Hospitalization: ☐ Yes ☐ No

Day(s) of Absence: ☐ Yes, _____ day(s) ☐ No

Indicate the Part(s) of Body Injured〔please mark "X" in the appropriate box(es)〕

☐ Head ☐ Eye ☐ Neck
☐ Hand ☐ Arm ☐ Torso
☐ Leg ☐ Foot ☐ Others. Please Specify_____

Indicate the Cause(s) of Accident〔please mark "X" in the appropriate box(es)〕

☐ Fall from Height ☐ Fall on Level Ground
☐ Fall of Object ☐ Stepping on or Striking Against Object
☐ Clamp, Stab or Cut ☐ Overexertion or Sprain
☐ Exposure to or Contact with Extreme Temperatures ☐ Contact with Electrical Current
☐ Exposure to or Contact with Harmful Substance and Radioactive Substance ☐ Injured by Animal
☐ Injury Caused by a Means of Transportation and the Undertaking of Labour Activities
☐ Accident Occurred on the Way to and from Work While Typhoon Signal No.8 or Above is Hoisted
☐ Accident Occurred on the Way to and from Work While Travelling to and from the Workplace by the Means of Transport Provided by the Employer
☐ Accident Occurred on the Way to and from Work While Travelling to and from the Workplace by the Means of Transport **not** Provided by the Employer
☐ Other Accidents Occurred on the Way to and from Work. Please Specify:_____
☐ Others. Please Specify:_____

Signature of Submitter and Company Stamp: _____

Date of Submission: _____/_____/_____ (dd/mm/yyyy)

The person filling out this form acknowledges that the personal data provided by himself/herself to the Labour Affairs Bureau (DSAL) will be for the handling process of the work-related injury case filed in the DSAL. The person filling out this form has the right to request access to and correction of his/her personal data held by the DSAL. To exercise the right of access, the person filling out this form shall apply in writing to the DSAL. To exercise the right of correction, the person filling out this form may apply to the DSAL, either in person or in writing. In compliance with legal obligations, the DSAL may transfer the personal data provided by the person filling out this form to other administrative organs, judicial organs, etc.