employment & labour
Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

S 39

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 130/ 1993
FORM TO APPOINT DESIGNATED OFFICIAL TO MANAGE COID CLAIMS IN TERMS OF SECTION 39 (3)(a)

A. DETAILS OF THE EMPLOYER/MEDICAL SERVICE PROVIDER/THIRD PARTY:

Company Registration Number:	9	9											
MSP practice number:													

Company /MSP Name: _____

Company / MSP Address: _____

_____Postal Code_____

Designation: _____

Address: _____

Suburb: _____ City: _____ Postcode: _____

Phone Number: _____ Cell Number: _____

Email: _____

Initial Surname (MSP / Employer Representative):_____

Signature (MSP / Employer Representative): _____ Date: _____ /_____ /_____

Compensation Fund
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FOR FURTHER ENQUIRIES CONTACT YOUR NEAREST DEPARTMENTOF LABOUR OFFICE

B. DETAILS OF NOMINATED USER

First Name: _____ Last Name: _____

Start Date: _____ /_____ /_____ Period of employment (years/months)**:** _____**/**_____

Position Title: _____

Gender: (circle one) M / F Date of Birth: _____/_____/_____

Identity Number: | | | | | | | | | | | | | | | |

Work phone: _____ Cell phone number _____

Email Address: _____

Declaration by nominated user:

I, _____**hereby declare that the particulars that will be completed by me when registering a claim at the Compensation Fund, of an alleged injury on duty or occupational disease, are to the best of my knowledge, accurate and will regard information as confidential.**

User Signature**:** _____ Date**:** _____ **/**_____ **/**_____

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