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FORM 2

EMPLOYEES' COMPENSATION ORDINANCE (CAP. 282)

SECTION 15

NOTICE BY EMPLOYER OF THE DEATH OF AN EMPLOYEE OR OF AN ACCIDENT TO AN EMPLOYEE RESULTING IN DEATH OR INCAPACITY

Important Notes

(1) To be completed and returned in DUPLICATE to the Commissioner for Labour -

(a) WITHIN 7 DAYS of the accident in the case of death; or

(b) WITHIN 14 DAYS of the accident in the case of injury; or

(c) WITHIN such period of time as required by the Commissioner for Labour.

(2) An employer who fails to give notice as required or who gives any false or misleading information to the Commissioner for Labour may be prosecuted.

(3) Part I must be completed for each employee. Part II is to be completed only if the accident occurred on a construction site.

(4) If more than one employee was injured or died as a result of an accident, please complete a separate form in duplicate for each employee.

(5) Please '✓' in the appropriate box.

(6) Please read the instructions carefully before completing this Form.

FORM 2

EMPLOYEES' COMPENSATION ORDINANCE
(CAP. 282)

SECTION 15

NOTICE BY EMPLOYER OF THE DEATH OF AN EMPLOYEE OR OF AN ACCIDENT TO AN EMPLOYEE RESULTING IN DEATH OR INCAPACITY

To the Commissioner for Labour

I declare that the information given in this form is, to the best of my knowledge, true and accurate.

Signature : _____ (for and on behalf of the employer)

Name (in block letters) : _____

Position : ☐ Sole proprietor ☐ Partner ☐ Manager ☐ Officer

Date : _____

_____
Chop of Company ***(Note 1)***

A. Particulars of the employee **➢Part I≺**

Name of employee (Surname first)			Identity Card/Passport No.
Telephone No.	Fax No.	Address	
Date of Birth _____ /_____ /_____ Day/Month/Year	Sex ☐ Male ☐ Female	Occupation	An apprentice ☐ Yes ☐ No

B. Particulars of employer

Name of employing company/person		Business Registration Certificate No. ***(Note 2)***
Telephone No.	Address	Trade
Fax No.		

C. Particulars of principal contractor/holding company ***(Note 3)***

Name of principal contractor/holding company		Business Registration Certificate No.
Telephone No.	Address	Trade
Fax No.		

D. Description of accident

Describe how the accident happened and state what the employee was doing at the time ***(Note 4)***			
State whether the accident occurred in the course of work ☐ Yes ☐ No	Date of accident _____ /_____ /_____ Day/Month/Year	Time of accident _____ a.m./p.m.	Result of accident ☐ Death ☐ Injury
Address of the place of accident		Name of hospital/clinic where the employee received treatment	

E. Details of insurance ***(Note 5)***

Name and address of insurance company at the time of accident (Please refer to the insurance policy)	Policy No.

F. Details of earnings of the employee

Average number of working days per month	Rest day is
☐ 22 ☐ 24 ☐ 26 ☐ 30 ☐ Others _____ (please specify)	(a) ☐ not paid ☐ paid (b) ☐ not fixed ☐ fixed on _____ (Day of week)

Details of earnings per month for the month immediately preceding the date of accident: ***(Note 6)***

(a) Basic salary/wages $_____ / month

(b) Food allowances/value of free food provided by employer $_____ / month

(c) Other items : _____ $_____ / month
(please specify)

Total (a) + (b) + (c) $_____ / month

Average monthly earnings of the employee for the past 12 months (or total period of employment, if less than 12 months) preceding the accident were

$_____ / month

G. Fatal accident (to be completed where accident results in death)

Whether police was notified	Name and address of next-of-kin of the deceased employee	Relationship with the deceased employee
☐ Yes _____ (name of police station) ☐ No		Telephone No.

H. Direct settlement (to be completed only where the injury results in temporary incapacity for not more than 7 days and no permanent incapacity, and the employer and employee have chosen to directly settle the employees' compensation claim)

Period of sick leave	Amount of compensation:
from ____ /____ /____ to ____ /____ /____ Day / Month / Year Day / Month / Year ____ /____ /____ to ____ /____ /____ Day / Month / Year Day / Month / Year Total number of sick leave days : _____ days	$ _____ ☐ paid ☐ to be paid on____ /____ /____ Day / Month / Year

I. Place of accident (tick one box)

The accident occurred in — ***(Note 7)***

Construction site	Shipyard	Manufactory	Others
☐ 01 Building worksite	☐ 04 Floating vessel	☐ 07 Production area	☐ 11 Container yard
☐ 02 Civil worksite	☐ 05 Non-floating vessel	☐ 08 Maintenance workshop	☐ 12 Catering establishment
☐ 03 Renovation/repair of existing buildings	☐ 06 Maintenance workshop	☐ 09 Loading/unloading area	☐ 13 Please specify _____
		☐ 10 Storage area	

Activity carried out on the site at the time of accident ***(Note 8)***

J. Nature of injury ***(Note 9)***

Describe the nature of injury

Indicate nature of injury (tick one box) —

☐ 01 Abrasion	☐ 06 Contusion & bruise	☐ 11 Electric shock	☐ 16 Poisoning
☐ 02 Amputation	☐ 07 Concussion	☐ 12 Fracture	☐ 17 Irritation
☐ 03 Asphyxia	☐ 08 Laceration and cut	☐ 13 Puncture wound	☐ 18 Nausea
☐ 04 Burn (heat)	☐ 09 Dislocation	☐ 14 Sprain & strain	☐ 19 Multiple injuries
☐ 05 Burn	☐ 10 Crushing	☐ 15 Freezing	☐ 20 Others (please specify) _____

Part of body injured (tick one box) —

Head	Neck & Trunk	Upper Limbs	Lower Limbs	
☐ 21 Skull/scalp	☐ 31 Neck	☐ 41 Finger	☐ 51 Hip	☐ 61 Multiple locations (please specify) _____
☐ 22 Eye	☐ 32 Back	☐ 42 Hand/palm	☐ 52 Thigh	
☐ 23 Ear	☐ 33 Chest	☐ 43 Forearm	☐ 53 Knee	
☐ 24 Mouth/tooth	☐ 34 Abdomen	☐ 44 Elbow	☐ 54 Leg	
☐ 25 Nose	☐ 35 Trunk	☐ 45 Upper arm	☐ 55 Ankle	
☐ 26 Face	☐ 36 Pelvis/groin	☐ 46 Shoulder	☐ 56 Foot	

K. Type of accident (tick one box) ***(Note 9)***

☐ 01 Trapped in or between objects	☐ 05 Striking against fixed or stationary object	☐ 10 Trapped by collapsing or overturning object	☐ 15 Exposure to fire
☐ 02 Injured whilst lifting or carrying	☐ 06 Striking against moving object	☐ 11 Struck by moving or falling object	☐ 16 Exposure to explosion
☐ 03 Slip, trip or fall on same level	☐ 07 Stepping on object	☐ 12 Struck by moving vehicle	☐ 17 Others (Please specify) _____
☐ 04 Fall of person from height* _____ metres	☐ 08 Exposure to or contact with harmful substance	☐ 13 Contact with moving machinery or object being machined	
	☐ 09 Contact with electricity or electric discharge	☐ 14 Drowning	

* distance through which person fell

L. Agents involved, if any (tick one or more boxes) ***(Note 9)***

☐ 01	Equipment for lifting/ conveying	☐ 04	Material/product being handled or stored	☐ 07	Movable container or package of any kind	☐ 10	Electricity supply, wiring apparatus or equipment
☐ 02	Portable power or hand tools	☐ 05	Ladder or working at height	☐ 08	Floor, ground, stairs or any working surface	☐ 11	Vehicle or associated equipment or machinery
☐ 03	Other machinery, please specify:	☐ 06	Sewage, manhole or other confined space	☐ 09	Gas, vapour, dust or fume	☐ 12	Others (Please specify)

Type : _____

Part causing injury:

☐ (a) prime mover

☐ (b) transmission part

☐ (c) working part

Describe briefly the agents you have indicated ***(Note 9)***

M. Sketch (to supplement the descriptions given above, if considered necessary)

For official use only

I.A./Non-I.A. ☐

Investigation ☐

Processed by ☐

➢End of Part I≺

➢Part II ≺

(To be completed if the accident occurred on a construction site)

N. Type of work performed by the employee at the time of accident (tick one box)

☐ 01	Concreting	☐ 07	Painting	☐ 13	Trench work	☐ 19	Slope work
☐ 02	Woodworking	☐ 08	Plastering	☐ 14	Gas pipe fitting	☐ 20	Others (please specify)
☐ 03	Glazier work	☐ 09	Arc/gas welding	☐ 15	Water pipe fitting		
☐ 04	Reinforcement bar bending	☐ 10	Formwork erection	☐ 16	Electrical wiring		
☐ 05	Bamboo scaffolding	☐ 11	Brick laying	☐ 17	Material handling		_____
☐ 06	Tubular scaffolding	☐ 12	Caisson work	☐ 18	Lift installation		

Whereabouts on the site such work was performed

O. Machinery involved, if any (tick one or more boxes) ***(Note 10)***

☐ 01	Skip/material hoist	☐ 06	Hydraulic crane	☐ 11	Bar bender
☐ 02	Passenger hoist/builders' lift	☐ 07	Suspended working platform	☐ 12	Concrete mixer
☐ 03	Tower crane	☐ 08	Boatswain's chair	☐ 13	Air compressor/receiver
☐ 04	Mobile crane	☐ 09	Pile driver	☐ 14	Others (please specify)
☐ 05	Lorry-mounted crane	☐ 10	Boring jig		

_____

P. Transporting or construction machinery involved, if any (tick one box)

☐ 01	Dump truck	☐ 04	Bulldozer	☐ 07	Others (please specify)
☐ 02	Loader	☐ 05	Grader		
☐ 03	Excavator	☐ 06	Compacting roller		_____

➢ End of Part II≺

Explanatory Notes

Note 1: The signature and company chop which appear in both copies of Form 2 submitted to the Commissioner for Labour should be in the original.

Note 2: If the Business Registration Certificate No. is not available, the Identity Card No. of the employing person should be entered.

Note 3: Section C on particulars of principal contractor/holding company should be completed only when the employer is either —

(a) a subcontractor; or

(b) a subsidiary of a holding company within the meaning of the Companies Ordinance (Cap. 622) and which is covered by and specified in the insurance policy taken out by the group of companies to which it belongs.

Note 4: Describe how the accident happened, state what the employee was doing at the time and give details of how the accident happened, e.g. what work was the injured doing, what factors (directly and indirectly) leading to the accident, and how he was injured, etc.

Note 5: The name and address of the insurer as appeared on the insurance policy, instead of those of the broker or agent, should be entered here.

Note 6: Earnings include —

(a) cash wages;

(b) the value of any privilege or benefit which can be estimated in cash, e.g. food, fuel or quarters supplied to the employee if, as a result of the accident, he is deprived of any of them;

(c) overtime or other special remuneration for work done, whether in the form of bonus, allowance or otherwise, if it is of a constant nature; and

(d) customary tips.

But remuneration for intermittent overtime, casual payments of a non-recurrent nature, the value of travelling allowances or concession and the employer's contributions to provident funds are not included.

Note 7: *Construction Site*

Building worksite: site for building substructure, superstructure, etc.

Civil worksite: site for building roads, bridges, etc.

Renovation/repair of existing buildings: internal or external renovation, repairing, painting or external wall cleaning, etc. (Note: Fitting-out in new buildings should be regarded as a building worksite.).

Shipyard

Floating vessel: ship building or repairing conducted on floating shipyard or floating vessel.

Non-floating vessel: ship building or repairing conducted on slipway or shore.

Maintenance workshop: maintenance workshop of the shipyard where parts of ships are machined, repaired or maintained.

Manufactory

Production area: production workshop or any location where actual production is being carried out.

Maintenance workshop: maintenance workshop of the manufactory where machinery parts are machined, repaired or maintained.

Loading/unloading area: location inside the manufactory assigned for loading and unloading activities including cargo handling.

Storage area: location inside the manufactory used for storage purpose.

Others

Container yard: the location where container handling, stacking and maintenance work, etc. are being carried out.

Note 8: Please briefly describe the main function of the workplace at the time of the accident.

Note 9: Please give details on the injury sustained, e.g. while working on a working platform, an employee twisted his ankle and fell 3 m onto the ground.

In the above example, the following boxes in sections J, K and L should be marked —

- In section J *Nature of injury*: Sprain & strain (box 14).
- In section J *Part of body injured*: Ankle (box 55).
- In section K *Type of accident*: Fall of person from 3 m (box 04).
- In section L *Agents involved*: Ladder or working at height (box 05).
- In the description of the agents indicated: A platform constructed of a plank which measured 5 m long by 2 m wide and by 5 mm thick.

Note 10: If none of the machinery provided is suitable, please tick box 14 and specify the name of the machinery or briefly describe the type of machinery involved.

Supplementary Information on Accidents on Construction Sites

Explanatory Note:

*This is **not** a statutory form required to be submitted under the Employees' Compensation Ordinance for reporting accident. However, the co-operation of employers is sought to complete Sections I to VI below for accidents occurred on construction sites. The supplementary information will be used for the purpose of accident analysis within Government and by the public bodies concerned.*

I. Particulars of Worksite

Commencement of Construction Work : _____/_____ (Month / Year)	Expected Completion Date: _____/_____ (Month / Year)
Name of Principal Contractor:_____ Site Address: _____ Contract No. (if available): _____ Date of Accident: _____ Contact Telephone: _____	_____ Chop of Company

II. Particulars of Project

(A) Nature of Project ☐ Civil Engineering ☐ Superstructure ☐ Maintenance and Repair

(B) Private Project ☐ Yes ☐ No

If Yes, please give name and contact telephone no. of authorized person or project manager

Name: _____(Position: _____)

Tel. No.: _____

If No, please indicate in (C) below the type of public works, government or related organisation project

(C) Public Works, Government or Related Organisation Project

☐ 01 Architectural Services Department	☐ 08 Water Supplies Department	☐ 18 Food & Environmental Hygiene Department
☐ 02 Buildings Department	☐ 09 Housing Department	☐ 19 Civil Engineering & Development Department
☐ 04 Drainage Services Department	☐ 12 Airport Authority Hong Kong	☐ 20 MTR Corporation Limited
☐ 05 Electrical & Mechanical Services Department	☐ 14 Environmental Protection Department	☐ 22 Hong Kong Housing Society
☐ 06 Highways Department	☐ 15 Home Affairs Department	☐ 99 Others (please specify)_____

III. Imported Labour of Labour Importation Scheme for the Construction Sector

☐ Yes ☐ No

IV. Particulars of Place of Fall (If Injured by Fall from Height)

☐ 01 Bamboo scaffold	☐ 04 Working platform/falsework	☐ 07 Ladder
☐ 02 Fragile structure	☐ 05 Unfenced edges & lift shaft opening	☐ 08 Others
☐ 03 Material hoistway	☐ 06 Unfenced/insecurely covered opening	_____

V. Ethnicity

☐ 01 Chinese	☐ 04 Indonesian	☐ 07 Pakistani	☐ 10 Other Asian
☐ 02 Filipino	☐ 05 Japanese	☐ 08 Thai	☐ 11 Others
☐ 03 Indian	☐ 06 Nepalese	☐ 09 White	_____

VI. Language Ability

Spoken		Reading		Written	
Cantonese	☐ Fluent ☐ Fair ☐ Nil	Chinese	☐ Fluent ☐ Fair ☐ Nil	Chinese	☐ Fluent ☐ Fair ☐ Nil
Putonghua	☐ Fluent ☐ Fair ☐ Nil				
English	☐ Fluent ☐ Fair ☐ Nil	English	☐ Fluent ☐ Fair ☐ Nil	English	☐ Fluent ☐ Fair ☐ Nil
Others _____	☐ Fluent ☐ Fair	Others _____	☐ Fluent ☐ Fair	Others_____	☐ Fluent ☐ Fair

Please '✓' in the appropriate box.

Employees' Compensation Division – Operations
Labour Department
Statement of Purpose of Collection of Personal Data

Important Notes to Employers
on Compliance with Personal Data (Privacy) Ordinance (Cap. 486)

By completing Form 2/2A/2B, you are providing personal data in respect of you and your employee to the Employees' Compensation Division, Labour Department. Please ensure that you have complied with the relevant requirements of Personal Data (Privacy) Ordinance (Cap. 486) when disclosing and transferring the personal data of your employee. For non-fatal cases, please also make sure that **you and your employee** have read the following Statement of Purpose of Collection of Personal Data before your submission of Form 2/2A/2B.

Purpose of Collection

1. Yours and the injured employee's personal data collected by the Employees' Compensation Division – Operations of the Labour Department (ECD) may be used for one or more of the following purposes –

(a) To process a claim for compensation under the Employees' Compensation Ordinance (the Ordinance), or an application for the Brewin Trust Fund or other assistance schemes.
(b) To conduct employees' compensation assessments under the Ordinance.
(c) To enforce relevant provisions of the Ordinance and other legislations administered by the Labour Department.
(d) To investigate accidents.
(e) To make case referrals and take follow-up actions for the Pilot Rehabilitation Programme for Employees Injured at Work.
(f) To compile statistics and conduct research.
(g) Any other purposes as may be required or permitted by law.

2. Except where required by the Ordinance, the provision of personal data is voluntary. However, the Labour Department may not be able to process the case or carry out the activities mentioned in paragraph 1 if the personal data concerned is not provided.

Classes of Transferees of Personal Data

3. For the purpose of carrying out the work mentioned in paragraph 1, ECD may transfer your personal data to the following parties, as well as collecting the personal data from them –

(a) Parties relevant to the employees' compensation claim including injured employee, family member(s) of the deceased employee, employer, principal contractor, sub-contractor, holding company, insurer or agents authorised by the aforementioned parties to handle the compensation claim.
(b) Employees' Compensation Assessment Board.
(c) The Judiciary / Legal Aid Department / lawyers appointed by you.
(d) Hospital Authority / relevant hospital(s), clinic(s) and medical practitioner(s).
(e) Employees Compensation Assistance Fund Board.
(f) Brewin Trust Fund Committee / government department(s) or organisation(s) administering other assistance schemes.
(g) The contractor and service providers engaged to implement the Pilot Rehabilitation Programme for Employees Injured at Work.
(h) Relevant divisions under the Labour Department.
(i) Government bureaux and department(s) and other relevant organisation(s).
(j) Consultant(s) engaged to compile statistics or conduct research.

Access to Personal Data

4. You have the right to request access to and correction of the personal data as provided under sections 18 and 22 and Principle 6 of Schedule 1 of the Personal Data (Privacy) Ordinance. The right of access includes the right to obtain a copy of the personal data subject to payment of a fee.

Enquiries

5. Any enquiries concerning the personal data provided to ECD, including making data access and correction request, should be addressed to the case officer who handles your employees' compensation claim.

6. For any request for access to personal data, please complete the latest Data Access Request Form as specified by the Privacy Commissioner for Personal Data.

Submission of Form 2 / 2A / 2B

Completed Form 2 / 2A / 2B should be submitted **in duplicate** to the following office of the Employees' Compensation Division of the Labour Department:

	Address of the Employees' Compensation Division's Office
Work Injury Cases	**Employees' Compensation Division** **Operations – Central Processing Team** Room 1007, 10/F, Cheung Sha Wan Government Offices, 303 Cheung Sha Wan Road, Kowloon
Fatal Cases	**Fatal Cases Office** Room 601, 6/F, Harbour Building, 38 Pier Road, Central, Hong Kong

- For any enquiries on submission of the forms, please call 2717 1771 (the hotline is handled by "1823").

- The Employees' Compensation Division will normally inform you/your company of the case reference number as well as the handling office of your case within 1 month after the receipt of the completed forms. If no such information is received by then, please call 2150 6364 (for work injury cases) or 2852 3994 (for fatal cases) for enquiry.

- For the addresses of all offices of the Employees' Compensation Division, please visit the Labour Department's website (https://www.labour.gov.hk/eng/tele/ec.htm) or call 2717 1771 for details.

Employees' Compensation Division
Labour Department

Notes on Application for Settlement of Employees' Compensation Case by 'Paper Medical Clearance'

To speed up the processing of an employees' compensation case, both the employer and the employee may apply to the Labour Department (LD) to settle the case by 'Paper Medical Clearance' (PMC). Should the application be approved, the injured employee will not be required to attend the medical clearance interview in person at the Occupational Medicine Unit (OMU) of LD.

Conditions for Application

The application must fulfill **all of** the following conditions:

1. there is no dispute over the case;
2. the period of sick leave should last for more than 7 days (if the period of sick leave does not exceed 7 days, the employer and the employee should settle the case via direct payment by employer or agreement between employer and employee in accordance with S.10(11) or S.16CA of the Employees' Compensation Ordinance (ECO) respectively*);
3. the injury does not lead to any permanent incapacity;
4. the injury does not involve damage to teeth or the need for fitting of prostheses or surgical appliances;
5. all medical certificates are issued by registered medical practitioners, registered Chinese medicine practitioners or registered dentists;
6. the employee's sick leave has already come to an end;
7. the employer must provide copy of all of the employee's medical certificates in respect of the employees' compensation case; and
8. for occupational disease case, it should be the one specified in the Second Schedule of the Ordinance as advised by the Occupational Health Officer.

Application made by both parties (i.e. both the employer and the employee signed the attached Application Form)

If both the employer and the employee agree to settle the case by PMC, please complete and return the Application Form signed by both parties to LD. A Certificate of Compensation Assessment (Form 5) stating the amount of compensation payable under ECO to settle the case will be issued directly to both the employer and the employee after the application is approved.

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* *If the employer is unable to settle the employees' compensation case by the way specified under the ECO and wishes to apply for PMC, please contact the case handling office of Employees' Compensation Division first.*

Application made solely by the employer (i.e. only the employer signed the attached Application Form) which is applicable in the following two situations

Situation 1:-

The employer proposes to settle the case by PMC, but is unable to have the employee sign the Application Form.

Situation 2:-

LD has issued a notification to the employee to attend the medical clearance interview in person at OMU, but despite being repeatedly urged to do so, the employee still fails to attend the appointment on time rendering the case cannot be formally settled.

In the above two situations, the employer may return the completed and signed Application Form to LD first, and LD will then issue a letter to inform the employee that the case will be handled by PMC. Unless the employee objects to this arrangement, LD will issue Form 5 direct to both parties stating the amount of compensation payable under ECO to settle the case after the application is approved.

Application Procedures

Please fill in the attached Application Form and send it back to the office of the Employees' Compensation Division which handles the relevant injury case, together with all documents specified in the Form. Please contact the case handling office if you have any enquiries.

- **For non-reported cases, please submit the Application Form while reporting the case to the following office:**

Employees' Compensation Division **Operations – Central Processing Team**	Room 1007, 10/F, Cheung Sha Wan Government Offices, 303 Cheung Sha Wan Road, Kowloon

- **For reported cases, please submit the Application Form to the following offices in accordance with the case reference no.:**

Employees' Compensation Division **Operations – Team A** ● for cases with reference no. starting with "13" and "15" (e.g. 15-2019-00001, 13-2020-12345)	Room 1605, 16/F, Southorn Centre, 130 Hennessy Road, Wanchai Hong Kong
Employees' Compensation Division **Operations – Team B** ● for cases with reference no. starting with "05" and "07"	18/F, One Mong Kok Road Commercial Centre, 1 Mong Kok Road, Kowloon

(e.g. 07-2019-00001, 05-2020-12345)	
Employees' Compensation Division **Operations – Team C** ● for cases with reference no. starting with "17" and "19" (e.g. 19-2019-00001, 17-2020-12345)	6/F, Tsuen Wan Government Offices, 38 Sai Lau Kok Road, Tsuen Wan, New Territories
Employees' Compensation Division **Operations – Team D** ● for cases with reference no. starting with "02", "03" and "04" (e.g. 03-2019-00001, 02-2020-12345, 04-2020-12345) ● for cases with reference no. starting with "21" (e.g. 21-2019-00001, 21-2020-12345)	Rooms 05-06, 23/F, KOLOUR•Tsuen Wan I, 68 Chung On Street, Tsuen Wan, New Territories Room 239, 2/F, Shatin Government Offices, 1 Sheung Wo Che Road, Shatin, New Territories
Employees' Compensation Division **Operations – Team E** ● for cases with reference number starting with "09" (e.g. 09-2019-00001, 09-2020-12345)	18/F, One Mong Kok Road Commercial Centre, 1 Mong Kok Road, Kowloon

<u>Important Notice</u>

LD retains the final decision on the approval of the application of PMC. Should the application be approved, the employee will not be required to attend the medical clearance in person. LD will issue directly to the employer and the employee a Certificate of Compensation Assessment (Form 5) stating the amount of compensation payable under the Ordinance.

Settlement of Employees' Compensation Case by 'Paper Medical Clearance' Application Form

(Please read the Notes on Application before completing this form)

To: Commissioner for Labour

Case reference (if any): _____

Name of employer (in block letters): _____

_____

Name of injured employee (in block letters): _____

HKID card number of injured employee: _____

Latest correspondence address of injured employee: _____

_____

I. Information on the Employees' Compensation Case

Date of accident: _____/_____/_____ (DD/MM/YY)

(Note: The sick leave of the employee must have come to an end, all copies of medical certificates are submitted together with this application form, all the medical certificates are endorsed by a registered medical practitioner, a registered Chinese medical practitioner or a registered dentist)

Periods of sick leave:

From : _____ to : _____

From : _____ to : _____

From : _____ to : _____

From : _____ to : _____

From : _____ to : _____

From : _____ to : _____

From : _____ to : _____

From : _____ to : _____

(Please use separate sheet for insufficient space)

The injured employee worked and earned full pay for the following day(s), thus this day/these days was/were excluded in the calculation of periodical payment.

_____

II. Application for Paper Medical Clearance is (please tick the appropriate box)

- ☐ with consent of both employer and employee
- ☐ made by employer only

III. Declaration

I/We hereby declare that the information given in this form is, to the best of my/our knowledge, true and accurate. I/we agree to make use of the Paper Medical Clearance by the Labour Department to settle the above employees' compensation case and understand that the injured employee will not be arranged to undergo medical assessment.

I/We have read and understood that the application must fulfill the following conditions:

1. there is no dispute over the case;
2. the period of sick leave should last for more than 7 days (if the period of sick leave does not exceed 7 days, the employer and the employee should settle the case via direct payment by employer or agreement between employer and employee in accordance with S.10(11) or S.16CA of the Employees' Compensation Ordinance respectively);
3. the injury does not lead to any permanent incapacity;
4. the injury does not involve damage to teeth or the need for fitting of prostheses or surgical appliances;
5. all medical certificates are issued by registered medical practitioners, registered Chinese medicine practitioners or registered dentists;
6. the employee's sick leave has already come to an end;
7. the employer must provide copy of all of the employee's medical certificates in respect of the employees' compensation case; and
8. for occupational disease case, it should be the one specified in the Second Schedule of the Ordinance as advised by the Occupational Health Officer.

Signature of employer's rep.: _____ Signature of employee: _____

Name: _____ Name: _____

_____

Post: _____ Date: _____

Company chop: (*No signature of employee is required for application made by employer only.*)

_____

Date: _____

Note: The signatures and chop must be original.

Important Notice

The Labour Department (LD) retains the final decision on the approval of the application of Paper Medical Clearance. Should the application be approved, the employee will not be required to attend the medical clearance (formerly known as sick leave clearance) in person. LD will issue directly to the employer and the employee a Certificate of Compensation Assessment (Form 5) stating the amount of compensation payable under the Ordinance.