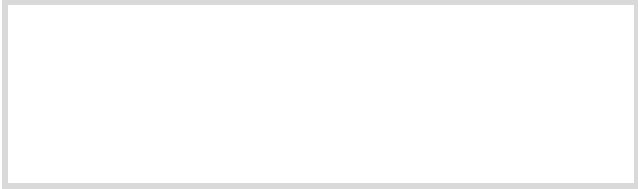




Kitengo	Cheo Kazini
Nambari ya Madai	
Tarehe ya Ombi	
Tarehe ya Jeraha	



Jinsi ya Kutuma Ombi: 1) Kamilisha na utie sahihi kwenye sehemu ya mfanyakazi ya fomu hii. 2) Patia mwajiri na daktari wako wakamilishe sehemu yao. 3) Yatume makaratasi haya kwa anwani iliyo hapa juu. Maswali? Wasiliana na meneja wako wa Madai.

**Sehemu ya
 Mfanyakazi**

Wakati wa kujeruhiwa, nilikuwa nikifanya kazi: _____ masaa kwa siku _____ siku kwa wiki.
 Kwa sasa ninafanya kazi: _____ masaa kwa siku _____ siku kwa wiki.
Jumla ya mapato yangu, kabla hayajakatwa, kwa kipindi cha kazi cha: _____ hadi _____ Zilikuwa \$ _____
 Katika ile siku ya majeraha, je, mwajiri wako alikuwa akilipia sehemu yoyote ya marupurupu ya matibabu, meno na/au bima ya macho yako na/au ya familia yako, au kukupa makao, malazi na/au mafuta ya gari (huduma)?
 Ndio La
 Je, ungali unapokea marupurupu haya? Ndio La Tarehe yalipositishwa _____
 Katika wakati huu wa kazi, mwajiri wangu wa sasa analipia/alikuwa akilipia marupurupu yangu ya matibabu, macho, au meno
 Ndio La

Kwa kutia sahihi hapa chini, Mimi nathibitisha yafuatayo: Ninafahamu kwamba ikiwa nitapeana taarifa ya urongo kuhusu shughuli zangu au hali yangu ya kimwili, Nitahitajika kurejesha marupurupu yangu na huenda nikakabiliwa na adhabu za kisheria. Ninafahamu kwamba ni lazima niripoti kwenye fomu hii kazi yoyote iliyofanywa (iliyolipiwa au isiyolipiwa), ikiwa daktari wangu ataniruhusu kurejelea majukumu kamili, ikiwa nitawekwa kizuizini, au ikiwa ulezi wa watoto wangu utabadilika.

Tarehe	Sahihi ya Mfanyakazi
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Employer's Section To be completed by employer or a copy of your payroll record for the above period can be attached.

Wages were paid for the period _____ to _____ Gross Wage paid \$ _____
 During this period: # work hours available _____ # hours worked _____
 Were vacation wages paid during this period? No Yes Amount paid \$ _____
 Were sick leave wages paid during this period? No Yes Amount paid \$ _____
 Were holiday wages paid during this period? No Yes Amount paid \$ _____
 Are you currently contributing to the worker and/or worker's family medical, dental and/or vision benefits, or providing housing, board and/or fuel (utilities)? No Date ended _____
 Yes Amount of contribution \$ _____ Please check if your contribution was by the Hour Day Week Month
 Name of employer _____ Phone Number _____

Date	I certify that the earnings shown above are correct, according to our records.
Employer's signature	Title

Physician's Section Diagnosis due to workplace injury or illness: _____

The present disability allows the worker to perform only Modified/lighter duty
 Reduced hours # hours per day _____ # days per week _____
 List and explain physical restrictions: _____

Have you advised the worker to return to pre-injury work schedule or pre-injury duties? <input type="checkbox"/> No <input type="checkbox"/> Yes, on _____	If No, when do you anticipate the worker will be able to return to pre-injury work schedule or pre-injury duties? _____
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Are there factors impeding recovery, such as unrelated medical conditions, socio-economic or chemical dependency? Yes No
 If yes, explain and use additional sheets if needed.

Has the worker's condition, due to this injury, reached maximum medical improvement? Yes No

Will permanent impairment result from this injury? Yes No Undetermined

Comments:

Phone #

Date

Physician's signature
