

Claim Number:

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993
(Previously Workmen's Compensation Act, 1941)

GOGGLE QUESTIONNAIRE

Employee: Date of accident:

Employer:

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1. Do you supply your employees with goggles/eye shields/welding masks for use when performing work such as this employee was doing?
 2. Was the appropriate protective device readily available to this employee at the time of the accident?
 3. Was the employee using this device when the accident happened?
 4. If not, he should state his reasons for not using it.
 5. Your comments on the employee's explanations are required.
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REPLY:

1.
2.
3.
4. Employee's reasons:
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SIGNATURE OF EMPLOYEE

5. Employer's comments:
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SIGNATURE OF EMPLOYER

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DATE