

**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 :	<input type="checkbox"/> Sole proprietor <input type="checkbox"/> Partner <input type="checkbox"/> Manager <input type="checkbox"/> Officer
Date : _____	_____ Chop of Company <i>(Note 1)</i>

**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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation	An apprentice <input type="checkbox"/> Yes <input type="checkbox"/> No

**B. Particulars of employer**

Name of employing company/person		Business Registration Certificate No. <i>(Note 2)</i>
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 <i>(Note 4)</i>			
State whether the accident occurred in the course of work <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of accident ____ / ____ / ____ Day/Month/Year	Time of accident _____ a.m./p.m.	Result of accident <input type="checkbox"/> Death <input type="checkbox"/> 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.
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**F. Details of earnings of the employee**

Average number of working days per month <input type="checkbox"/> 22 <input type="checkbox"/> 24 <input type="checkbox"/> 26 <input type="checkbox"/> 30 <input type="checkbox"/> Others _____ (please specify)	Rest day is (a) <input type="checkbox"/> not paid <input type="checkbox"/> paid (b) <input type="checkbox"/> not fixed <input type="checkbox"/> fixed on _____ (Day of week)
Details of earnings per month for the month immediately preceding the date of accident: <b>(Note 6)</b>	
(a) Basic salary/wages	\$ _____ / month
(b) Food allowances/value of free food provided by employer	\$ _____ / month
(c) Other items : _____ (please specify)	\$ _____ / month
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 <input type="checkbox"/> Yes _____ (name of police station) <input type="checkbox"/> No	Name and address of next-of-kin of the deceased employee	Relationship with the deceased employee
		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  from _____ / _____ / _____ to _____ / _____ / _____ Day / Month / Year      Day / Month / Year  _____ / _____ / _____ to _____ / _____ / _____ Day / Month / Year      Day / Month / Year  Total number of sick leave days : _____ days	Amount of compensation: \$ _____  <input type="checkbox"/> paid <input type="checkbox"/> to be paid on _____ / _____ / _____ Day / Month / Year
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I. Place of accident (tick one box)

The accident occurred in — (Note 7)

<u>Construction site</u>		<u>Shipyards</u>		<u>Manufactory</u>		<u>Others</u>	
<input type="checkbox"/> 01	Building worksite	<input type="checkbox"/> 04	Floating vessel	<input type="checkbox"/> 07	Production area	<input type="checkbox"/> 11	Container yard
<input type="checkbox"/> 02	Civil worksite	<input type="checkbox"/> 05	Non-floating vessel	<input type="checkbox"/> 08	Maintenance workshop	<input type="checkbox"/> 12	Catering establishment
<input type="checkbox"/> 03	Renovation/repair of existing buildings	<input type="checkbox"/> 06	Maintenance workshop	<input type="checkbox"/> 09	Loading/unloading area	<input type="checkbox"/> 13	Please specify
				<input type="checkbox"/> 10	Storage area		

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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) —

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

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Part of body injured (tick one box) —

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

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

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

\* distance through which person fell

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

<input type="checkbox"/> 01 Equipment for lifting/ conveying	<input type="checkbox"/> 04 Material/product being handled or stored	<input type="checkbox"/> 07 Movable container or package of any kind	<input type="checkbox"/> 10 Electricity supply, wiring apparatus or equipment
<input type="checkbox"/> 02 Portable power or hand tools	<input type="checkbox"/> 05 Ladder or working at height	<input type="checkbox"/> 08 Floor, ground, stairs or any working surface	<input type="checkbox"/> 11 Vehicle or associated equipment or machinery
<input type="checkbox"/> 03 Other machinery, please specify:  Type : _____ Part causing injury:  <input type="checkbox"/> (a) prime mover <input type="checkbox"/> (b) transmission part <input type="checkbox"/> (c) working part	<input type="checkbox"/> 06 Sewage, manhole or other confined space	<input type="checkbox"/> 09 Gas, vapour, dust or fume	<input type="checkbox"/> 12 Others (Please specify)  _____

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. <input type="text"/>
	Investigation <input type="text"/>
	Processed by <input type="text"/>

➤ 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)*

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

Whereabouts on the site such work was performed

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

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

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

<input type="checkbox"/> 01 Dump truck	<input type="checkbox"/> 04 Bulldozer	<input type="checkbox"/> 07 Others (please specify)
<input type="checkbox"/> 02 Loader	<input type="checkbox"/> 05 Grader	
<input type="checkbox"/> 03 Excavator	<input type="checkbox"/> 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. 32) 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.



