

APPENDIX 9

REPORT OF A CASE OF DISEASE

Filling in this form

This form must be filled in by an employer or other responsible person

Part A

About you

1. What is your full name?

2. What is your job title?

3. What is your telephone number?

About your organisation

4. What is the name of your organisation?

5. What is its address and postcode?

6. Does the affected person usually work at this address?

Yes Go to question 7

No Where do they normally work?

7. What type of work does the organisation do?

PART B

About the affected persons

1. What is their full name?

2. What is their date of birth?

3. What is their job title?

4. Are they

male?

female?

5. Is the affect person (tick one box)

one of your employees?

on a training scheme? Give details.

on work experience?

employed by someone else?
Give details:

other? Give details:

PART C

The disease you are reporting

1. Please give:
 - the name of the disease, and the type of work it is associated with; or
 - the name and number of the disease (*from Schedule 3 of the Regulations – see the accompanying notes*).

2. What is the date of the statement of the doctor who first diagnosed or confirmed the disease?

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3. What is the name and address of the doctor?

PART D

Describing the work that led to the disease

Please describe any work done by the affect person which might have led to them getting the disease.

If the disease is thought to have been caused by exposure to an agent at work (*e.g. a specific chemical*) please say what that agent is.

Give any other information which is relevant.

Give your description here

Continue your description here

Part E

Your signature

Signature

Date

/ /

Where to send the form

Please send it to the Enforcing Authority for the place where the affected person works. If you do not know the Enforcing Authority, send it to the nearest HSE office.