**COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 130/ 1993**
**FORM TO APPOINT DESIGNATED OFFICIAL TO MANAGE COID CLAIMS IN TERMS OF SECTION 39 (3)(a)**

## A. DETAILS OF THE EMPLOYER/MEDICAL SERVICE PROVIDER/THIRD PARTY:

Company Registration Number:

| 9 | 9 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

MSP practice number:

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

Company /MSP Name: ______________________________________________________________________

Company / MSP Address: ___________________________________________________________________

___________________________________________________________Postal Code________________________

Designation: ___________________________________________________________________________

Address: _______________________________________________________________________________

Suburb: ________________________________ City: ______________________ Postcode: ____________

Phone Number: ____________________________ Cell Number: ______________________________

Email: _________________________________________________________________________________

Initial Surname (MSP / Employer Representative):______________________________________________

Signature (MSP / Employer Representative): ______________________ Date: _____ /_____ /______

**FOR FURTHER ENQUIRIES CONTACT YOUR NEAREST DEPARTMENTOF LABOUR OFFICE**

## B. DETAILS OF NOMINATED USER

First Name: ______________________________ Last Name: _______________________________

Start Date: _____ /_____ /_____ Period of employment (years/months)**:** ___________**/**___________

Position Title: ____________________________________________

Gender: (circle one) M / F Date of Birth: _______/_______/____________

Identity Number: | | | | | | | | | | | | | | | | |

Work phone: ___________________________ Cell phone number _______________________________

Email Address: ______________________________________________________________________

**Declaration by nominated user:**

**I, ______________________________________________hereby declare that the particulars that will be completed by me when registering a claim at the Compensation Fund, of an alleged injury on duty or occupational disease, are to the best of my knowledge, accurate and will regard information as confidential.**

User Signature**:** _________________________ Date**:** _____ **/**_____ **/**______

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