Chapter:	282A	**EMPLOYEES' COMPENSATION REGULATIONS**	Gazette Number	Version Date

		Empowering section		30/06/1997

(Cap 282 section 49)

[1 December 1953]

(Originally G.N.A. 161 of 1953)

Regulation:	1	**Citation**		30/06/1997

These regulations may be cited as the Employees' Compensation Regulations.

(44 of 1980 s. 15)

Regulation:	2	**Interpretation**		30/06/1997

In these regulations-

"Schedule" (附表) means a Schedule to these Regulations;

"the Ordinance" (本條例) means the Employees' Compensation Ordinance (Cap 282).

Regulation:	3	**Notice of accident**		30/06/1997

The notice of an accident required by section 14 of the Ordinance to be given to an employer by or on behalf of an employee if given in writing may be in Form 1 in the Schedule where the accident caused personal injury and in Form 1A in the Schedule in the case of incapacity or death due to an occupational disease.

(L.N. 45 of 1965; 44 of 1980 s. 15)

Regulation:	4	**Notice of accident**		30/06/1997

Notice of an accident required by section 15(1), (1A)(a), (1B), (1C) or (2) of the Ordinance to be given by an employer to the Commissioner for Labour shall be in writing and-

(a) if the notice is required under section 15(1), (1A)(a), (1B), or (2), shall be in Form 2 in the Schedule where the accident caused personal injury and in Form 2A in the Schedule in the case of incapacity or death due to an occupational disease; and

(b) if the notice is required under section 15(1C), shall be in Form 2 or Form 2A, as the case may be, in the Schedule.

(L.N. 208 of 1983; L.N. 264 of 1992; 67 of 1996 s. 9)

Regulation:	5	**Certificate as to compensation payable**	L.N. 245 of 2000	01/08/2000

Where-

(a) a certificate stating the amount of compensation payable by an employer has been issued under section 16A(2) or (5) of the Ordinance and it is desired to proceed in accordance with section 16A(8) of the Ordinance; or

(b) (Repealed 36 of 1996 s. 29)

(c) a Certificate of Interim Payment or Review Certificate of Interim Payment has been issued and it is desired to proceed in accordance with section 6C(14) of the Ordinance; or (52 of 2000 s. 35)

(d) a Certificate of Compensation Assessment for Fatal Case or Review Certificate of Compensation Assessment for Fatal Case has been issued and it is desired to proceed in accordance with section 6D(9) of the Ordinance; or (52 of 2000 s. 35)

(e) a Certificate for Funeral and Medical Attendance Expenses or Review Certificate for Funeral and Medical Attendance Expenses has been issued and it is desired to proceed in accordance with section

6E(14) of the ordinance, (52 of 2000 s. 35)
the details of such certificate shall be given in Form 3 in the Schedule and lodged with Registrar of the Court.
(L.N. 208 of 1983; 36 of 1996 s. 29)

Regulation:	6	**Delivering of notice**		30/06/1997

Save as is otherwise specially provided in the Ordinance or these regulations every notice required by the Ordinance or these regulations may be given by delivering the same at, or sending it by registered post to, the last known residence or place of business or employment of the person to whom it is to be given.

Regulation:	7	**Forms**		30/06/1997

The forms contained in the Schedule or forms to the like effect shall be used with such variations and modifications as the circumstances may require.

Schedule:		**SCHEDULE**	L.N. 163 of 2013	03/03/2014

[regulation 7]

FORM 1 [regulation 3]

EMPLOYEES' COMPENSATION ORDINANCE

(Chapter 282)

NOTICE OF ACCIDENT BY OR ON BEHALF OF EMPLOYEE

To: (1) .....
.....
.....

Notice is hereby given that (2) .....
.....
on the (3) ..... day of ..... 19 ..... at (4) .....
..... met with an accident causing his (5) .....
and that the cause of the injury/death was (6) .....
.....

And notice is hereby further given that in consequence thereof compensation is claimed from you.

Dated this ..... day of ..... 19 .....

(7) .....
.....
.....

---

(1) Name and address of the employer or principal contractor.
(2) Full name and address of the employee.
(3) Date of accident.
(4) Place of the accident.
(5) Whether disablement or death.
(6) State in plain and ordinary terms the cause or the injury or death.

(7) Signature and address of person giving the notice.

FORM 1A [regulation 3]

EMPLOYEE'S COMPENSATION ORDINANCE

(Chapter 282)

NOTICE BY OR ON BEHALF OF EMPLOYEE OF INCAPACITY

OR DEATH DUE TO OCCUPATIONAL DISEASE

To: [1] .....
.....
.....

Notice is hereby given that [2] .....
.....
on the [3] ..... day of ..... 19 ..... was found to be suffering from the following occupational disease .....
..... believed to be due to his employment by you upon the following work [4] .....
resulting in the death/partial/total incapacity of a permanent/temporary nature [5] of the employee.

And notice is hereby further given that in consequence thereof compensation is claimed from you.

Dated this ..... day of ..... 19 .....

[6] .....

---

(1) Name and address of the employer or principal contractor.
(2) Full name and address of the employee.
(3) Date upon which disease is said to have been discovered.
(4) State nature of the work which is said to have caused the occupational disease.
(5) Delete whichever is inapplicable.
(6) Signature, name and address of person giving the notice.

FORM 2 [regulation 4]

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: ☐ Sole proprietor ☐ Partner
☐ Manager ☐ Officer

Date: _____ _____
Chop of Company (Note 1)

-Part I-

A. Particulars of the employee

Name of employee (Surname first)			Identity Card/Passport No.
Telephone No.	Fax No.	Address	
Date of birth _____/_____/____ Day/Month/Year	Sex ☐ Male ☐ Female	Occupation	An apprentice ☐ Yes ☐ No

B. Particulars of employer

Name of employing company/person		Business Registration Certificate No. (Note 2)
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 (Note 4)			
State whether the accident occurred in the course of work ☐ Yes ☐ No	Date of accident _____/_____/____ Day/Month/Year	Time of accident _____ a.m./p.m.	Result of accident ☐ Death ☐ 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.

F. Details of earnings of the employee

Average number of working days per month ☐ 22 ☐ 24 ☐ 26 ☐ 30 ☐ Others _____ (please specify)	Rest day is (a) ☐ not paid ☐ paid (b) ☐ not fixed ☐ fixed on _____ (Day of week)
Details of earnings per month for the month immediately preceding the date of accident: (Note 6) (a) Basic salary/wages $ _____/month (b) Food allowances/value of free food provided by employer $ _____/month (c) Other items: _____ $ _____/month (please specify) 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 ☐ Yes _____ (name of police station) ☐ 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: $ _____ ☐ paid ☐ to be paid on _____/_____/____ Day/Month/Year

I. Place of accident (tick one box)

The accident occurred in-(Note 7)
Construction site Shipyard Manufactory Others

☐ 01 Building worksite
☐ 02 Civil worksite
☐ 03 Renovation/repair of existing buildings
☐ 04 Floating vessel
☐ 05 Non-floating vessel
☐ 06 Maintenance workshop
☐ 07 Production area
☐ 08 Maintenance workshop
☐ 09 Loading/unloading area
☐ 10 Storage area
☐ 11 Container yard
☐ 12 Catering establishment
☐ 13 Please specify
_____

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)-

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

Part of body injured (tick one box)-

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

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

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

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

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

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)

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

Whereabouts on the site such work was performed

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

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

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

☐ 01 Dump truck	☐ 04 Bulldozer	☐ 07 Others (please specify)
☐ 02 Loader	☐ 05 Grader	
☐ 03 Excavator	☐ 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 622) 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.

(L.N. 469 of 1996; 28 of 2012 ss. 912 & 920)

FORM 2A [regulation 4]

EMPLOYEES' COMPENSATION ORDINANCE
(CAP 282)

SECTION 15

NOTICE BY EMPLOYER OF THE DEATH OR INCAPACITY OF AN EMPLOYEE DUE TO OCCUPATIONAL DISEASE

Important Notes

(1) To be completed and returned in DUPLICATE to the Commissioner for Labour-
  (a) WITHIN 7 DAYS of the death of the employee; or
  (b) WITHIN 14 DAYS of the employee's incapacity; 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) Please "✓" in the appropriate box.

(4) Please read the instructions carefully before completing this Form.

FORM 2A

EMPLOYEES' COMPENSATION ORDINANCE
(CAP 282)

SECTION 15

NOTICE BY EMPLOYER OF THE DEATH OR INCAPACITY OF AN EMPLOYEE DUE TO OCCUPATIONAL DISEASE

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: ☐ Sole proprietor ☐ Partner
☐ Manager ☐ Officer

Date: _____ _____
Chop of Company (Note 1)

A. Particulars of the employee

Name of employee (Surname first)		Identity Card/Passport No.
Telephone No.	Fax No.	Address
Date of birth	Sex	Occupation

_____/_____/____ Day/Month/Year	☐Male ☐Female	
An apprentice ☐ Yes ☐ No	Duration of employment From _____ to _____	

B. Particulars of employer

Name of employing company/person		Business Registration Certificate No. (Note 2)
Telephone No. Fax No.	Address	Trade

C. Particulars of principal contractor/holding company (Note 3)

Name of principal contractor/holding company		Business Registration Certificate No.
Telephone No. Fax No.	Address	Trade

D. Particulars of the occupational disease

Name of hospital or clinic where the employee received treatment	
Date of commencement of the occupational disease _____/_____/_____ Day/Month/Year	Disease suffering from
Type of work attributed to the occupational disease	The disease resulted in ☐ temporary incapacity ☐ permanent incapacity ☐ death on _____/_____/_____ Day/Month/Year

E. Details of insurance (Note 4)

Name and address of insurance company at the time of the employee's incapacity or death (Please refer to the insurance policy)	Policy No.

F. Details of earnings of the employee

Average number of working days per month ☐ 22 ☐ 24 ☐ 26 ☐ 30 ☐ Others _____ (please specify)	Rest day is (a) ☐ not paid ☐ paid (b) ☐ not fixed ☐ fixed on _____ (Day of week)

Details of earnings per month for the month immediately preceding the date of the employee's incapacity or death: (Note 5)

(a) Basic salary/wages $ _____/month
(b) Food allowances/value of free food provided by employer $ _____/month
(c) Other items: _____ $ _____/month
(please specify)

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 employee's incapacity or death were

$ _____/month

G. Fatal case (to be completed where the occupational disease results in death)

Whether police was notified	Name and address of next-of-kin of the deceased employee	Relationship with the deceased employee

☐ Yes _____ (name of police station) ☐ No		Telephone No.

H. Direct settlement (to be completed only where the occupational disease 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	Amount of compensation:
from _____/_____/___ to _____/_____/___ Day/Month/Year Day/Month/Year _____/_____/___ to _____/_____/____ Day/Month/Year Day/Month/Year Total number of sick leave days: _____ days	$ _____ ☐ paid ☐ to be paid on _____/_____/____ Day/Month/Year

Explanatory Notes

Note 1: The signature and company chop which appear in both copies of Form 2A 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 622) and which is covered by and specified in the insurance policy taken out by the group of companies to which it belongs.

Note 4: 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 5: 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.

(L.N. 469 of 1996; 28 of 2012 ss. 912 & 920)

FORM 3 [regulation 5]

EMPLOYEES' COMPENSATION ORDINANCE
(Chapter 282)

DETAILS OF CERTIFICATE AS TO THE AMOUNT OF COMPENSATION PAYABLE BY THE EMPLOYER

(This form must be completed and lodged with the Registrar of the Court by the party who desires the certificate to be made an order of the Court)

1. Name, address and business of employer .....
   .....
   .....
2. (a) Name and address of employee .....
   .....
   (b) Occupation[1] .....
   (c) Age ..... (d) Sex .....
   (e) Compensation already received in respect of this accident (if any).....
   .....
3. (a) Date of accident .....
   (b) Cause of accident .....
   .....
   (c) Nature and circumstances of injury [2] .....
   .....
   .....
4. Contract of employment [3] .....
   .....
5. Date of certificate .....
   .....
6. Amount of compensation determined by the Commissioner for Labour [4].....
   .....
   .....
   (a) Amount payable in a lump sum .....
   (b) Amount and period of periodical payments .....
   .....
   (c) To whom payable .....
7. Date of the Commissioner for Labour's issue of certificate as to compensation .....
   .....
   .....
8. Any other information .....
   .....
   .....

I, ... do solemnly and sincerely declare that the foregoing particulars stated are true and I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the Oaths and Declarations Ordinance (Cap 11).

.....
Signature of applicant.

Declared at ..... in Hong Kong this ..... day of ..... 19 .....

Before me,

.....
Notary Public,
or Commissioner for Oaths.

---

(1) Full details of the nature of the work and duties on which the employee was employed at the date of the accident.
(2) Give full details and state whether incapacity is total or partial, permanent or temporary. If partial, the degree, and, if temporary, the period of actual or estimated incapacity must be given.
(3) The monthly earnings must be stated, specifying the value of food, fuel or quarters if the employee has been

deprived thereof as a result of the accident. (See sections 3 and 11 of the Ordinance.)

(4) Copy of certificate as determined by the Commissioner for Labour must be attached.

(L.N. 383 of 1995; 36 of 1996 s. 30; 47 of 1997 s. 10)

(Schedule replaced L.N. 208 of 1983)