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Title:

Contractor Monthly Statistical Reports

		` "X Is T	(Mark with "X") Is This Company a:							Injuries		Number of Lost Time Incidents				PERFORMAN CE OF COMPANY WHILST WORKING ON PROJECT		CONTACT DETAILS OF COMPANY						
No.	Name of Contractor Company (if this company is a sub-contractor, then indicate the name of the Principal Contractor company in this column)	Principal Contractor	Sub-Contractor	Vendor Number with Eskom (if applicable)	Number of workers	Workers Complet ed Medical Surveilla nce	Number of workers Complet ed Site	Number of workers complet ed other training on Health and Safety	Number of Near Miss Incidents	Number of First Aid Incidents	Number of Medical Incidents	Number of Occupational Diseases (OD's)	Number of Fatals	Number of LostTime Injuries (excl. Fatalities and OD's)	Number of Los ents	No of DAYS without a Lost Time Incident	No of averaged HRS without a Lost Time Incident	Na	me of CEO	Contact details of CEO (Telephone number, email address and postal address)	Name of Site Construction Supervisor (CR 6.1 appointee)	Contact details of Site Construction Supervisor (Telephone number, email address and postal address)	Name of Health and Safety Practitioner/M anager	Contact details of Health and Safety Practitioner/M anager (Telephone number, email address and postal address)
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