CHAPTER XV

OCCUPATIONAL HEALTH

Section A

Workmen's Compensation Act and Medical Examination and Certification under the Workmen's Compensation Act

1501. Introduction.(1) The general rules governing payment of compensation to workmen injured in accidents arising out of and in the course of their employment are embodied in the Workmen's Compensation Act, 1923, and the rules framed thereunder, as amended from time to time.

(2) This Section deals with only the duties of Railway doctors regarding examination, certification and assessment of injury and/or loss in earning capacity of the workmen for purposes of payment of compensation under the Workmen's Compensation Act, 1923.

(3) The detailed rules are contained in Section 11 of the Workmen's Compensation Act, 1923 and Rules 13 to 18 of the Workmen's Compensation Rules, 1924, which are to be complied with by the Railway doctors as and when they take up cases of injured workmen for medical examination under the said Act.

1502. Definition and Application:- (1) "The Workmen's Compensation Act is an act to provide for the payment by certain classes of employers to their workmen of compensation for injury by accident"

(2) "Work man" means any person (other than a person whose employment is of a casual nature and who is employed otherwise than for the purpose of the employer's trade or business) who is -

i) a Railway servant as defined in clause 34 of section 2 of the Railways Act,1989 (24 0f 1989)] not permanently employed in any administrative, district or sub-divisional office of a Railway and not employed in any such capacity as is specified in Schedule II or

ii) employed in any such capacity as is specified in Schedule II ,

whether the contract of the employment was made before or after passing of this Act and whether such contract is expressed or implied, oral or in writing; ***but does not include any person working in the capacity of the armed forces of the Union;*** and any reference to a workman who has been injured shall, where the workman is dead, include a reference to his dependants or any of them.

(3) "Wages" includes any privilege or benefit which is capable of being estimated in money, other than a travelling allowance or the value of any travelling concession or a contribution paid by the employer of a workman towards any pension or provident fund or a sum paid to a workman to cover any special expenses entailed on him by the nature of his employment;

(4) "Partial disablement " means,

where the disablement is of a temporary nature, such disablement as reduces the earning capacity of a workman in any employment in which he was engaged at the time of the accident resulting in the disablement and, where the disablement is of a permanent nature, such disablement as reduces his earning capacity in every employment which he was capable of undertaking at that time: provided that every injury specified in Part II of schedule I shall be deemed to result in permanent partial disablement;

(5)" Total disablement" means

such disablement whether of a temporary or permanent nature, as incapacitates a workman for all work which he was capable of performing at the time of the accident resulting in such disablement: provided that permanent total disablement shall be deemed to result from every injury specified in part I of schedule I or from any combination of injures specified in Part II thereof where the aggregate percentage of the loss of earning capacity as specified in the said Part II against those injuries amounts to 100%.or more;

(6) Compensation:

If personal injury is caused to a workman by accident arising out of and in the course of his employment, his employer shall be liable to pay compensation in accordance with the provision of this act provided that the employer shall not be so liable.

a) in respect of any injury which does not result in total or partial disablement of the workman for a period exceeding three days.

b) in respect of any injury not resulting in death or permanent total disablement caused by an accident which is directly attributable to:

i)The workman having seen at the time there of under the influence of drink or drugs.

ii)The willful disobedience of the workman to an order expressively given or to a rule expressively framed, for the purpose of securing the safety of workman or

iii)The willful removal or disregard by the workman of any safety guard or other device he knew to have been provided for the purpose of securing the safety of workman.

(7)" Dependants" means any of the following relatives of deceased workman, namely;

i) a widow, a minor legitimate or adopted son, and unmarried legitimate or adopted daughter, or a widowed mother and ;
ii) if wholly or in part dependent on the earnings of the workman at the time of his death, a son or a daughter who has attained the age of 18 years and who is infirm;
iii) if wholly or in part dependant on the earning of the workman at the time of his death:-

a) a widower,
b) a parent other than a widowed mother,
c) a minor illegitimate son, an unmarried illegitimate daughter, legitimate or illegitimate or adopted if married and a minor or if widowed and a minor.
d) a minor brother or an unmarried sister or a widowed sister, if a minor.
e) a widowed daughter in law,
f) a minor child of a predeceased son,
g) a minor child of a predeceased daughter where no parent of the child is alive , or
h) a paternal grand parent if no parent of the workman is alive

(Extract from the Workmen's Compensation Act 1923 & the Workmen's Compensation Rules 1924 (1997 print)

(8) Unless otherwise specified, the term "Railway Medical Officer" will mean the following :-

(i) Assistant Divisional Medical Officer.
(ii) Divl. Medical Officer.
(iii) Sr.Divl.. Medical Officer

1503**. All injury cases to be examined carefully**:- (1) It is essential that all Railway doctors should be conversant with the Workmen's Compensation Act as they are likely to be called upon in the discharge of their duties to examine, certify and assess the loss of earning capacity and the consequent compensation to be paid therefor to Railway employees injured on duty and governed by the said Act.

(2) Besides this, a Railway doctor may have to appear before a Commissioner appointed under the Act to give evidence in cases of dispute between the administration and the employee. It is, therefore, necessary that every case of injury coming under the Workmen's Compensation Act should be viewed as a potential case likely to be brought before a Commissioner and every care should be taken to note down all particulars of such cases.

1504. **Medical Examination of injured workmen**:- If a workman sustains injury while on duty, his immediate superior will either arrange for the injured workman to be examined by the nearest Railway Medical Officer at the site of the accident, or will arrange for the injured workman to proceed, or to be conveyed, to the authorised medical officer with a memo on the prescribed form as given in Annexure I to this Chapter. The Railway medical officer, after examination of the injured workman, will issue, if the workman is not fit to return to work immediately, a sick certificate in the prescribed form (Sick certificate) as given in Annexure XI to chapter V with a rubber stamp bearing the words: "This injury is consistent with the statement that it was caused by accident", as well as a certificate in the prescribed form as given in Annexure II to this Chapter giving particulars of the part of the body injured, the nature of the injury - whether simple or grievous - and the probable period of disablement, and forward the same to the immediate superior of the injured workman.

1505. **Injury Report Register**:- (1) An entry of all cases of injuries with which a Railway doctor has to deal must be made in an accident register which is to be maintained in every hospital and health unit. This entry is in addition to the entries made in any other register, such as on daily attendance register or on case papers.

(2) The entry in the accident register must be made as soon as possible after the patient is seen for this first time and thus becomes an extremely valuable record of the first clinical examination. Sufficient space should be left below the entry so that additional information obtained later on such as X-ray reports, admission to hospital, or subsequent death of the patient during the period of treatment for the injuries can be entered neatly and without encroachment on the next entry.

(3) Records of injuries to employees " on or off duty ", family members of employees and members of the general public must be kept each in a separate section of the register. There should be diagrammatic figures on the reverse of the injury report, on which the details of injuries are to be shown.

(4) The Railway medical Officer at the time of examination will note carefully the list of injuries on the prescription slips which should not be destroyed as they may be required at any future date for assessing the extent of disablement for purposes of payment of compensation claimed by the injured workman. Prescription slips should also be treated as confidential documents.

1506. **Disposal of claim for an injury when no sign of injury is found**:- If a patient claims that he is injured and clinical examination shows no sign of injury, these facts must be recorded in the accident register, but all such cases are to be referred to the CMS/MS in-charge of the division.

1507. **Caution where no sign of injury is seen**. – Attending Medical Officer must make a clear distinction between the complaints of the patient and the physical signs of injuries observed. Doubtful cases should be referred to the CMS/MS in-charge of the Division, postponing a diagnosis and issue of certificate until his advice has been received. Pre-existing disease and deformities must be noted.

1508**. Case Sheets**:- (1) Case sheets should be made out for all cases of injuries and are to be used for making day-to-day notes on the progress of the cases, instructions from the CMS/MS in-charge of the Division, results of X-ray examination, and so on.

(2) These case papers are not to be handed over to a patient to be taken home, where it may be lost, mutilated or soiled, as it is a very valuable record of the case subsequent to the first entry in the accident register. It must be retained as an official record.

(3) CMS/MS s in-charge of the division will make their own local arrangements regarding the safe transmission of these injury case papers from their hospitals to subordinate hospitals and health units. In addition to the records outlined above entries of attendance of the injured person will be made also in the daily attendance register just as for any other patient, and the injury case paper will bear the serial number as recorded in the daily attendance register.

1509**. Certification and attendance of injured employees**:- (1) All injured employees are to be regarded from the beginning of attendance as persons making a claim or likely to make a claim that the injury was sustained on duty and, therefore, the Railway doctor must not assume that because the accident report in the prescribed form as given in Annexure III has not yet been received, the case is not one coming under the Workmen's Compensation Act, for often the accident report is received by the Railway doctor some time after the accident.

(2) When an employee attends a Railway hospital or health unit for an injury or alleged injury, he will be issued a sick certificate only if he is unable to perform his duties. If the attending Medical Officer is on doubt regarding the employee's fitness for work or whether the physical signs shown are due to an injury, the case shall be referred at once to the CMS/MS in-charge of the Division, certification being postponed until his advice is received.

(3) The CMS/MS s in-charge of the Division can make their own local arrangements regarding cases being sent up to them, but it is considered essential that at least all cases of injuries to the eye or of suspected fractures shall be sent to them for examination at once, if the patient is in a position to be transported safely, along with the injury case paper, otherwise, the CMS/MS in-charge of the Division may be called by the attending Medical Officer to the station where the injured person is lying. In the case of an eye injury, both the eyes must be examined and detailed notes made of their condition, and visual acuity figures recorded.

(4) In all cases of injury to the eye or near about the eye, vision is each eye at the time of admission and at the time of discharge should be recorded.

(5) If an employee is unfit to work and shows definite signs of injury, a sick certificate is to be issued immediately and if a definite diagnosis cannot be made, the best provisional diagnosis under the circumstances can be entered in the certificate.

(6) One of the functions of a Railway doctor is to fit work to man and man to work. To do this, close and repeated observation of the conditions and circumstances of work will need to be combined with constant study of men at work.

(7) The Railway doctor should, therefore, see that the workmen are in a good state of health and there is no gross defect in their visual acuity or in the body, which is likely to endanger them or their co-workers' safety.

(8) Visual acuity of all employees, met with an accident on duty, should be recorded both on the injury case sheet and the accident register.

(9) Further, when an employee has suffered from an eye injury, before he is discharged to duty, his visual acuity should be examined by the CMS/MS in-charge of the Division, and if his vision is below the standard required for his class of employment then he should be dealt with in accordance with the regulations for the medical examination of non-gazetted candidates and employees. Of course, the question of compensation would arise if the defect is due to a permanent injury arising out of and in the course of employment. In cases of injuries other than injury to the eye where visual acuity is found below the standard of his class of appointment, he should be dealt with under the regulations referred to.

1510. **Medical obstruction certificate**:- If the injured workman fails to carry out instructions regarding treatment, etc. as given by the Railway medical officer or absents himself while under treatment against the advice of the Railway Medical Officer, or refuses to submit himself for subsequent examination, or in any way obstructs the same, the Railway Medical Officer will issue a medical obstruction certificate in the pro forma as given in Annexure IV and send the same to the department superior of the injured workman.

1511. **Medical review certificate**:- If the injured workman, in whose favour a medical obstructions certificate has been issued, subsequently satisfies the Railway medical officer that there was no willful disregard of the instructions issued, that failure to attend the Railway dispensary was due to reasons beyond his control, and that he was under the treatment of a registered qualified medical practitioners, for which due intimation was given and necessary certificates produced, the Railway medical officer will issue a medical review certificate in the prescribed form as given in Annexure V and send the same to the departmental superior concerned.

1512. **Injury resulting in immediate death**:- In case of immediate death of a workman resulting from injuries arising out of an accident within the meaning of the Act, the departmental superior will arrange for the immediate attendance of the nearest Railway medical officer. The Railway medical officer, after examination, will issue a certificate in the prescribed form as given in Annexure VI and send the same immediately to the departmental superior concerned.

1513**. Injury resulting in subsequent death**:- In the first instance, the procedure laid down for an injured workman should be followed. On subsequent death of the workman, the Railway medical officer will issue a certificate in the prescribed form as given in Annexure VII and submit the same to the departmental superior concerned.

1514. **Resumption of duty by injured workman**:- (1) When an injured workman is fit to resume duty in his original post, the Railway medical officer will issue a fit certificate in the prescribed form (Sick & Fit Certificate)as given in Annexure XI to Chapter V.

(2) In the event of the injured workman not being fit to resume duty in his original post but fit for other posts, the Railway medical officer will submit a recommendation for alternative employment and follow the procedure laid down for such recommendation.

1515**. Issue of fresh certificate when the injury of the injured employee have healed but he acquires any other illness**:- If is fairly common for an injured employee to acquire another illness during the treatment for the injury and in such cases when the treatment for the injury is finished and the patient would be fit for duty, but because of the additional illness, he cannot be discharged to duty, then the procedure should be that, with the approval of the CMS/MS in-charge of the division, the patient should be issued a fit certificate with regard to the injury and re-admitted to the sick-list by the issue of another sick certificate on the same date is respect of the additional illness.

1516**. Assessment of loss of earning capacity and issue of certificate**:- (1) Before the injured workman is issued a fit certificate for his original post or in an alternative employment, the attending Medical Officer will refer the case to the CMS/MS in-charge of the Division concerned with the full history of the case and recommendation for change of employment, if any, for assessing the loss of earning capacity for permanent, partial or total disablement which may have resulted from the injury. The CMS/MS in-charge of the Division will, after personal examination of the case, advise the Medical Officer concerned to issue the necessary fit certificate if the employee is considered by him fit to resume duty in his original post. When it is considered that the employee is not fit to resume duty of his original post and is to be recommended alternative employment, the CMS/Ms in-charge of the division will follow the procedure laid down for the offer of alternative employment.

(2) The CMS/MS in-charge of the division/hospital after personal examination of the case referred by the attending Medical Officer, will assess and certify the loss of earning capacity according to Schedule I of the Workmen's Compensation Act, reproduced in Annexure VIII to this Chapter. Such a certificate should be issued in the prescribed form as given in Annexure X in triplicate. Two copies should be sent to the department superior concerned**.**

(3) If D.M.O is in independent charge of a hospital or division the certificate issued assessing the loss of earning capacity according to Schedule I to workman's compensation Act should be submitted to C.M.D for counter signature. Where CMS/MS is in-charge of the Division/hospital it will suffice if the certificate is counter signed by the CMS/MS in-charge of the division/hospital .

(Bd.'s No 82/H/5/4 dt. 06/07/82)

1517. **Non-Schedule injuries**:-(1) In case of injuries not included in Schedule I as reproduced in Annexure VIII, the CMS/MS in-charge of the division will refer the case to the Medical Board for assessment of loss of earning capacity, with full history of the case, giving particulars of the resulting disablement of the workman at that time. The Medical Board after assessment of the Loss of Earning capacity will send their recommendation to the C.M.D for acceptance.

(2) The Chief Medical Director will, either on the report of the Medical Board, or after personal examination of the injured workman, advise the CMS/MS in-charge of the Division, as early as possible, the loss of earning capacity assessed. The CMS/MS in-charge of the Division will then issue necessary certificate in the prescribed form as given in Annexure X. In all such cases, the decision of the Chief Medical Director will be final.

Note: A broad guideline for assessing non-scheduled injuries is given in Annexure IX to this chapter

(3) The C.M.S/.M.S in charge of the division will send in duplicate the certificate assessing the loss of earning capacity to the departmental superior concerned for necessary action.

1518. **Contractor's workmen**:- (1) Divisional Officers should advise the CMS/MS in-charge of the Division, of cases of workmen who sustain personal injury by accident arising out of and in the course of employment, whilst engaged by contractors for the purpose of carrying out trade or business of the Railway administration, to enable the latter to take necessary action to examine the workman. In cases where the workman engaged by a contractor is treated in a non-railway hospital/dispensary arrangements should be made to have the workman examined before they are discharged from the hospital.

(2) In the case of grievous hurt to a workman, engaged by a contractor, steps should be taken to record the evidence of the other workmen working on the spot as to how the accident occurred, to enable the administration to decide its liability under the Act.

1519. Occupational diseases:- (1) Occupational diseases, a list of which has been given in Schedule III of the Workmen's Compensation Act, also come within the purview of the Act for which compensation is to be paid to the workman as a result of any disability arising from such diseases.

(2) Drillers' Phthisis and Anthracosis are well known diseases. Saw mill workers of the workshops are exposed to dusty occupation for several hours in a day and are likely to suffer from chronic lung troubles. Liability to Plumbism in the manufacture of white lead, production of epitheliomatous-ulceration and cancer of the skin in those handling pitch, tar and oil, are all typical occupational diseases.

(3) The danger in inhaling irritating fumes and gases by plumbers and sewage workers, the risk of infection from Anthrax among persons handling horse-wound hair, hides and skin, liability to eye injuries from brilliant light and metal fume fever are also all typical occupational diseases. Besides the above diseases, poor ventilation, lack of cleanliness, overcrowding and faulty lighting arrangements tend to lower the general health of the employees. Industrial fatigue is mostly due to air stagnation and polluted atmosphere.

(4) In every workshop, there should be four persons out of every fifty workers trained in first aid.

1520. **Periodical medical examinations in respect of important occupational diseases**:- Persons engaged in occupations involving the use of substances as shown in first column, should be examined at intervals as shown in the second column, while the type of examination to be carried out has been indicated in the third and the last column of the following table:-

Substance	Intervals	Type of examination
Benzene and its homologues	Monthly	Blood picture.
Bichromate chrome	Fortnightly	Fingers and nasal septum for ulcers and perforations
Coal, coal dust, pitch and tar	Half-yearly	X-ray examination of the lungs and for warts.
Lead burning and smelting and	Quarterly	Blood picture and for palsy of the extensor muscles

manufacture of electric accumulator(battery workers).			of the wrists(wrist drop) and examination of gums.
Radio-active substances	... ...	Monthly	Finger tips and nails. Blood picture (Quarterly).
Silica	... ...	Yearly	X-ray examination of the lungs to watch the fibrotic changes.

Section B - Medical Examinations and Certification under the Factories Act & Occupational Safety

1521. **Medical examination and certification under the Factories Act**.- (1) The provisions of the Factories Act. 1948,(and the rules framed thereunder by the individual State Governments in respect of factories under their jurisdiction) are applicable to all Central Government factories employing ten or more workers where a manufacturing process is carried on with the aid of power, or twenty or more workers where a manufacturing process is carried on with the aid of powers, or twenty or more workers where a manufacturing process is carried on without the aid of power, but excludes, from its purview a Railway running shed.

(2) These provisions relate to many facets of factory working including health examination of persons engaged in dangerous occupations, supervision of a factory engaged in a manufacturing process which may be injurious to the health of workers employed therein, reporting of notifiable diseases, certification of fitness, provision of first aid appliances, etc. or to act as certifying surgeons when appointed by the State Government under Section 10 of the Factories Act.

1522. **Occupational Safety:-** Indian Railways employ the largest work force of industrial workers. It is essential to look after their health, safety and well being at their work place in order to ensure an increased production output. Occupational health is the prevention of disease and maintenance of the highest degree of physical, mental and social well being of workers in all occupations for health promotion, specific protection, early diagnosis and treatment. Occupational health aims at providing a comprehensive approach to deal with the relationship between work and the total health of man-starting right from the time of employment and extend throughout an employee's working life.

The milieu or " occupational environment" of the railway employees is influenced by external conditions which prevail at the place of work and which have a bearing on their health. The employee is placed in a highly complicated environment and a number of factors like physical agents, unguarded machine parts, psychosocial factors affect him at his workplace. The railway doctors and primarily the doctors working in workshops are responsible for their health and prevention of occupational disabilities.

The various measures to be undertaken for the prevention of occupational diseases are:

1) Pre-placement examination:

A very stringent and detailed medical examination should be done which includes a carefully detailed medical history, past disease conditions, present complaints, family history, personal habits including smoking, alcohol consumption and a thorough physical examination and investigations for example chest x-ray, Electro-cardiogram, vision testing, urine and blood examination, etc. The purpose of pre-placement examination is to place the right man in the right job so that the worker can perform his duties efficiently without detriment to his health.
A base line record of physical condition is thus established for future examination and epidemiology.

2) Periodic health examination:

This should be so designed to ensure surveillance over certain classes of employees who are exposed to specific risks and cumulative effects of specific occupations. The frequency and content of periodical medical examination will depend upon the type and nature of occupational exposure. If potentially vulnerable people can be identified at an early stage and/or before the onset of symptoms and persuaded to seek medical advice; treatment may hold out chances of control or cure. This examination affords an excellent opportunity to counsel the employees regarding correction of medical conditions that can later on lead to disability.

Particular care should be taken when the employees return after sickness, give medical certificates for leave etc., to assess the nature and degree of any disability and to assess suitability or otherwise of returning to the same job.

3) Medical and health care:

All workers are to be given optimum health facility. In the workshop, first aid services should be made available. First aid kits should be given in each shop and the supervisor or a motivated worker to be trained in first aid.

4) Supervision of working environment:

Periodic inspection of working environment to assess the accident potential of each area in a given workshop should be thoroughly studied by the doctors. The physician should pay frequent visits to the shop in order

to acquaint himself with the various aspects of the working environment such as temperature, lighting, ventilation, humidity, dust, fumes, gases, noise, vibration, air pollution and sanitation which have an important bearing on the worker's health. He should be acquainted with the raw materials, processes and products manufactures. He should also study the various aspects of occupational physiology such as occurrence of fatigue, shift work, weight carried by the workers, etc. Recommendations to prevent accidents and diseases likely to result from the physical and chemical hazards of the work environment should be made to the Works Manager from time to time. Such recommendations should be periodically revised and updated with the latest developments in the field.

5) Periodical inspection:

Periodical inspections of the workshop by the Medical Officers should be carried out to ensure that the recommended safety measures are actually being implemented.

6) Maintenance and analysis of records:

Proper records are essential for future planning, development and efficient operation of occupational health services. The worker's health record and occupational disability record must be maintained.

7) Health Education:

Health education is needed to being about a positive change in behaviour of employees in achieving optimum health. All the risks involved in the occupation in which he is employed and the measures to be taken for personal protection should be explained to him. The correct use of protective devices like masks, gloves, barrier creams, eye-protection devices should be explained to him. Simple rules of hygiene like hand washing, wearing clean clothes should also be impressed upon him. Health education material such as charts, posters should be displayed and handbills circulated from time to time, constantly reminding the worker of the potential health hazards and their prevention. Occupation and health are closely inter-related. The treating physician should blend clinical concepts and epidemiological approaches with prudence in examining the cause of disease associated with work place environment.

ANNEXURE-I

MEDICAL DEPARTMENT
WORKMEN'S COMPENSATION ACT

FORM OF MEDICAL MEMO FOR EMPLOYEES ALLEGED TO BE INJURED IN ACCIDENTS COVERED BY THE ACT.

Memo No. .....

The ADMO/DMO/Sr DMO .....station

PERSONS INJURED WHILE ON DUTY

The bearer.....is reported to have been injured in an accident arising out of and in the course of his employment at /in the .....on ……...and is sent for medical examination and treatment .

2. Cause of injury .....

3. Please issue the necessary certificate giving the nature and extent of the injury and the probable period of disablement.

{ Signature.....
Employer { Designation.....
{ .....

Date.....
Place.....
.....RAILWAY

ANNEXURE II

_____RAILWAY

WORKMEN'S COMPENSATION ACT

INJURY AND DISABLEMENT CERTIFICATE

Book No. …… Medical Certificate Page No. ……

I have examined …….

Ticket
—— No. …… who met with an accident on ……. 19……Part of body injured
Gang

……..

Nature of injury ……

His disablement is likely to continue for * more/less than …… days.

Date ……..
Place ……..

Railway doctor

Signature ……..
Designation ……

ANNEXURE III

……..RAILWAY

MEDICAL DEPARTMENT

WORKMEN'S COMPENSATION ACT

ACCIDENT REPORT

Reference No.

Department

Station

Dated

1. Date of accident
2 Time of day at which accident occurred
3. Place at which accident occurred (if not a Railway's premises it must be so stated),
4. Nature and cause of accident and detailed statement of the circum – stances under which it happened.
5. Nature of injury sustained, whether slight or serious
6. Name in full
7. Ticket or Gang No.
8. Designation
9. Department
10. Age
11. Date of appointment
12. Address
13. In case of death, name and address of nearest relative or dependent
14. Time and date of accident reported by employee
15. To whom reported
16. Method of report
17. If not reported by employee, how and when did Railway become aware of this accident ?
18. Did accident arise out of and in the course of his employment ?
19. If injured person has been disabled, state when first absent through accident.
20. Was first aid rendered ? If so, by whom ?

21. Was doctor called in at the time of accident ?

22. If so, name of the doctor

23. Was injured man sent to doctor ?

24. If so, name of the doctor

25. After investigation have you any suspicion -
    (a) as to the genuineness of the accident ?
    (b) that it did not occur on duty as described?
    (c) that the workman at the time was under influence of drink or drug ?
    (d) that there was willful removal or disobedience of the workman to an order expressly given or to a rule expressly framed for the purpose of securing safety of workman ?
    (e) that there was willful removal or disregard by the workman of any safety guard or other device which he knew to have been provided to secure the safety of workman ?

26. Names and designations of persons who can give corroborative Information (each must be interrogated before this question is answered).

    Eye witnesses

    Others

Station Master

Inspector

Foreman

Signature
Office-in-charge

Designation

ANNEXURE IV
MEDICAL DEPARTMENT
WORKMEN'S COMPENSATION ACT
MEDICAL OBSTRUCTION CERTIFICATE

Book No. .....

With reference to Medical certificate No. ..... dated. ..... Name ....

Ticket/gang No. ..... has refused to be attended by me/has deliberately disregarded my instructions.

His claim for compensation should be withheld from.....19....F.N. */A.N.*

Railway Medical Officer { Signature.....
{ designation.....
{ .....

Date.....
Place.....
.....Railway

ANNEXURE V

MEDICAL DEPARTMENT

WORKMEN COMPENSATION ACT

Book No. ..... **MEDICAL REVIEW CERTIFICATE**

.....(Name) Ticket /gang no…….....Disqualified for payment vide medical refusal or obstruction certificate no. .....….....date…….

(1) has now complied with instruction

(2) died on .....19....

*His claim for compensation should be reviewed for the full period from .....19.....
*. His claim for compensation should be withheld from .....19.....

Rly. Medical Officer {Signature.....
{Designation.....
{.....

Date.....
Place.....

- delete whichever is inapplicable

ANNEXURE VI

_____RAILWAY

MEDICAL DEPARTMENT

WORKMEN'S COMPENSATION ACT

IMMEDIATE DEATH CERTIFICATE

Name…….

Date of death……

Cause of death……..

Death * was/ * was not the result of injury received on…….19

Signature

Railway Doctor

Date Designation

Place

- Delete whichever is inapplicable.

ANNEXURE VII

_____RAILWAY

MEDICAL DEPARTMENT

WORKMEN'S COMPENSATION ACT

SUBSEQUENT DEATH CERTIFICATE

Book No. Page No.

I certify that……..(Name) Ticket/Gang No. referred to in Medical Certificate No……..of ……..19. died on 19

I * consider/* do not consider his death was the result of the accident.

Signature
Railway doctor

Date

Designation

Place

- Delete whichever is inapplicable.

Annexure-VIII

SCHEDLE I OF THE WORK MEN'S COMPENSATION ACT
PART -1

List of injuries deemed to result in permanent total disablement

Sl.	Description of injury	Percentage of loss of earnings Capacity
1.	Loss of both hands or amputation at higher sites	100
2.	Loss of one hand and one foot	100
3.	Double amputation through leg or thigh, or amputation through leg or thigh on one side and loss of other foot.	100
4.	Loss of sight to such an extent as to render the claimant unable to perform any work for which eye sight is essential	100
5.	Very severe facial disfigurement	100
6.	Absolute deafness	100

PART II
List of injuries deemed to Result in permanent partial disablement

Amputation cases, upper limbs (either arm)

1.	Amputation through shoulder joint	90
2.	Amputation below shoulder with stump less than 20.32 cms from tip of acromion	80
3.	Amputation from 20.32 cms from tip of acromion to less than 11.43 cms below tip of olecranon.	70
4.	Loss of a hand or of the thumb and four fingers of one hand or amputation from 11.43 cms below tip of olecranon	60
5.	Loss of thumb.	30
6.	Loss of thumb and its metacarpal bone.	40
7.	Loss of four fingers of one hand.	50
8.	Loss of three fingers of one hand.	30
9.	Loss of two fingers of one hand.	20
10.	Loss of terminal phalanx of thumb.	20
10A.	Guillotine amputation of tip of thumb without loss of bone.	10

Amputation cases, lower limbs

11.	Amputation of both feet resulting in end bearing stumps	90
12.	Amputation through both feet proximal to the metatarso-phalangeal joint	80
13.	Loss of all toes of both feet through the metatarso phalangeal joint	40
14.	Loss of all toes of both feet proximal to the proximal inter-phalangeal joint	30
15.	Loss of all toes of both feet distal to proximal inter-phalangeal joint	20
16.	Amputation at hip	90
17.	Amputation below hip with stump not exceeding 12.70 cms length measured form tip of great trochanter	80

18. Amputation below hip with stump exceeding 12.70 cms in length measured from tip of great trochanter but not beyond middle thigh	70
19. Amputation below middle thigh to 8.89 cm below knee	60
20. Amputation below knee with stump exceeding 8.89 cms but not exceeding 12.70cm	50
21. Amputation below knee with stump exceeding 12.70cm	50
22. Amputation of one foot resulting in end bearing	50
23. Amputation through one foot proximal to the metatarso phalangeal joint	50
24. Loss of all toes of one foot through the metatarso phalangeal joint	20

Other injuries

25. Loss of one eye, without complications the other being normal	40
26. Loss of vision of one eye without complications or disfigurement of eye-ball, the other being normal	30
26A Loss of Partial vision of one eye	10

Loss of

A- **Fingers of right or left hand--**

Index finger

27. Whole	14
28. Two phalanges	11
29. One phalanx	9
30. Guillotine amputation of tip without loss of bone	5

Middle finger

31. Whole	12
32. Two phalanges	9
33. One phalanx	7
34. Guillotine amputation of tip without loss of bone	4

Ring or little finger

35. Whole	7
36. Two phalanges	6
37. One phalanx	5
38. Guillotine amputation of tip without loss of bone	2

B-Toes of right or left foot

Great Toe

39. Through metatarso-phalangeal joint	14
40. Part, with some loss of bone	3

Any other toe

41. Through metatarso-phalangeal joint	3
42. Part, with some loss of bone	1

Tow toes of one foot, excluding great toe

43. Through metatarso -phalangeal joint	5
44. Part, with some loss of bone	1

Three toes of one foot, excluding great toe

45. Through metatarso-phalangeal joint	6
46. Part , with some loss of bone	3

Four toes of one foot, excluding great toe

47. Through metatarso-phalangeal joint	9
48. Part with some loss of bone	3

Note : complete and permanent loss of the use of any limb or member referred to in this schedule shall be deemed to be the equivalent of the loss of the limb or member.

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Annexure IX

(Manual for Orthopedic surgeon in evaluating permanent physical impairment: Courtesy American Academy of Orthopedic Surgeons.. Published by ALIMCO, Kanpur)

APPROXIMATE RATINGS OF PERMANENT PHYSICAL IMPAIRMENTS AND THEIR PHYSICAL LOSS OF FUNCTION.

The following specific permanent physical impairments and their percentage ratings are to be used only as guiding examples of *about what the rating should be in a corresponding individual case*. These ratings are adjusted to approximate relatives values of other parts of the body. They encompass pain, weakness, neuro-muscular and other reactions naturally expected to exist.

		Per cent Permanent Physical Impairment and Loss of Physical Function of Lower Extremity.
LOWER EXTREMITIES		
1.	Shortening	
	½ inch	5
	1 inch	10
	1 ½ inches	15
	2 inches	20
2.	Hip (Rating value to whole body 50%)	75
A.	Non union without reconstruction.	
B.	Arthroplasty, use of prosthesis able to Walk and stand at work, motion free to 25% to 50% of normal	40
C.	Osteotomy reconstruction, moderate Motion, 1 inch shortening, no contrature.	35
D.	Ankylosis and limited motion	
(a)	Total ankylosis, optimum position 15^0 flexion.	50
	(b) Limitation of motion	
(1)	Mild. A.P .motion from 0^0 to 120^0 flexion, rotation and lateral motion, abduction, adduction free to 50% of normal	15
(2)	Moderate. A.P. motion from 15^0 flexion deformity to 110^0 further flexion, rotation, lateral motion, abduction, and adduction free to 25% normal	30
(3)	Severe. A.P. motion from 30^0 Flexion deformity to 90^0 further flexion.	50
3.	Knee	
A.	Surgical removal internal or external Semilunar cartilage, no complications	5
B.	Surgical removal both cartilages, cruciate Intact.	20
C.	Ruptured cruciate ligament, repaired, moderate laxity.	20
	Not repaired, marked laxity	30
D.	Excision of patella	20
E.	Plateau fracture, depressed bone elevated, Semilunar excised	20
F.	Ankylosis and limited motion, total Ankylosis optimum position, 15^0 flexion	50

G. Limitation of motion

(a) Mild. 0^0 to 110^0 flexion 5

(b) Moderate 0^0 to 80^0 flexion 15

(c) Severe 0^0 to 60^0 flexion 35

(d) Severe. Limited from 15^0 flexion deformity with further flexion to 90^0 40

Percent Permanent Physical Impairment and Loss of Physical function to Foot(80% of leg)

5. Ankle and Foot

A. Eversion deformity 25^0 as in fracture lower end of fibula with avulsion medial ligaments, 20^0 eversion 20

B. Inversion deformity 20^0 15

C. Total Ankylosis ankle and foot (plantar arthrodesis)

(a) 10^0 plantar flexion 50

(b) Mal- position 30^0 plantar flexion 60

D. Ankylosis of foot, subtalar or triple Arthrodesis tarsal bones, ankle, free Motion 25

E. Ankylosis of tibia and talus, subtalar Joints free, optimum position 15^0 plantar Flexion 40

F. Limitation of motion in the ankle

(a) Mild. Motion limited from position of 90^0 right angle to 20^0 plantar flexion 10

(b) Moderate. Motion limited from Position of 10^0 plantar flexion to 20^0 plantar flexion 25

© Severe. Motion limited from position of 20^0 plantar flexion to 30^0 plantar flexion. 50

Per cent Permanent Physical Impairment and Loss of Physical Function to Foot

6. Foot

A. Ankylosis of tarsal metatarsal or mid tarsal joints

Mild 10

Severe 20

B. Limited Motion in the Foot

(a) Mild. Limited Motion with mild pain 10

(b) Moderate. Limitation of motion with pain 20

(c) Severe. Limitation of motion with pain 35

Per cent Permanent Physical Impairment and Loss of Physical Function To Toe

7. Toes

A. Complete ankylosis of metatarsophalangeal Joint, any toe 50

B. Complete ankylosis any toe, interphalangeal

Joint, favourable position semi-flexion. 10

Per cent Permanent Physical Impairment and Loss of Physical Function to Whole Arm

UPPER EXTREMITIES

8. Shoulder

A. Total ankylosis in optimum position abduction 60^0 flexion 10^0 rotation neutral position 50

B. Total ankylosis in mal-position Grade upward

C. Limitation of motion

(a) Mild. No abduction beyond 90^0 rotation only 40^0 with full flexion and extension 5

(b) Moderate. No abduction beyond 60^0 Rotation only 20^0, with flexion and extension limited to 30^0 20

(c) Severe. No abduction beyond 25^0 Rotation only 10^0 flexion and Extension limited to 20^0 50

D. Recurrent dislocation as frequently as Every 4 to 6 months 35

E. Resection distal end of clavicle (rate motion independently) 5

9. Elbow

Flexion and extension of forearm considered As 85% of arm, rotation of forearm considered As 15% of arm

A. Total ankylosis in optimum position Approximating mid-way between 90^0 Flexion and 180^0 extension(45^0 angle) (45^0 angle) 50

B. Total ankylosis in mal-position Grade upward

C. Limitation of motion -

(a) Mild. Motion limited from 10^0 Flexion to 100^0 further flexion 10

(b) Moderate. Motion limited from 30^0 Flexion to 75^0 further flexion 20

(c) Severe. Motion limited from45^0 Flexion to 90^0 further flexion 35

D. Flail elbow, pseudarthrosis above joint Line, wide motion but very unstable 65

E. Resection head of radius 15

10. Wrist

Percent permanent physical impairment and loss of physical function to hand

Excision distal end of ulna, flexion and Extension credited with 75% of hand, and Rotation 25% of hand 10

A. Total ankylosis in optimum position 35

B. Total ankylosis in mal-position of

Extreme flexion or extension — Grade upward

C. Limitation of motion

(a) Mild. Rotation normal 15 ^{0} palmar Flexion to 20 ^{0} dorsi-flexion — 10

(b) Moderate. Rotation limited to 30^{0} In semi-pronation, palmar flexion 10 ^{0} dorsiflexion 10 ^{o} — 20

(c) Severe. Rotation limited to 10 ^{0} in Position of full pronation, palmar Flexion 5 ^{0}, dorsiflexion 5^{0} — 25

Percent Permanent Physical Impairment and Loss of Physical Function to Individual finger

See Fig.1 (Relative value of digits To whole hand).

Note: Compare injured digit to uninjured digits.

11. Fingers - Ankylosis of joints (see Fig. 1 and 2)

A. Any digit (excluding the thumb)

(a) Total ankylosis of distal joint

1. Optimum position — 25
2. Mal-position (flexed 35 ^{0} or more) — 35

(b) Total ankylosis of proximal interphalangeal joint

1. Optimum position (flexed 35^{0}) — 50

2. Mal- position (approximately full Extension or full flexion) — 75

© Total ankylosis of both distal and Proximal interphalangeal joints

1. Optimum position — 75
2. Mal- position — 100

(d) Total ankylosis metacarpophalangeal joint

1. Optimum position (45^{0} flexion) — 45
2. Mal-position(approximately full Extension or full flexion) — 75

(e) Total ankylosis both interphalangeal Joints and metacarpophalangeal joint — 100

B. Thumb (See Fig. 3)

(a) Total ankylosis interphalangeal joint

1. Optimum position (0 ^{0} to 15 ^{0}) — 40
2. Mal-position (flexion greater than 15 ^{0}) — 65

(b)Total ankylosis metacarpophalangeal joint

1. Optimum position (up to 25 ^{0} flexion) — 50
2. Mal – position (flexion greater than 25 ^{0}) — 65

(c) Total ankylosis both interphalangeal and Metacarpophalangeal joints

1. Optimum position — 75
2. Mal – position — 85

(d) total ankylosis interphalangeal,
metacarpophalangeal, and carpometacarpophalangeal joints

1. Optimum position	90
2. Mal-position	95

(e) Total ankylosis carpometacarpal joint alone

1. Optimum position	10% hand
2. Mal-position	20% hand

C.Limitation of motion (fingers and thumb)

1. Mild. Total closing motion tip of digit , can flex to touch palm and thumb , and extend to 15 degree flexion grip fair	15
2. Moderate. Total closing motion tip of digit, lacks, 1/2 inch of touching palm and can extend to 30 degree flexion	20
3. Severe. Total closing motion tip of digit lacks 1" of touching palm and can extend to 45 degree flexion	75

D. Amputations of fingers (exclusive of thumb)

(a) Up to 1/2 of distal phalanx	25%digit
(b) From 1/2 to all of distal phalanx	50%digit
(c) any of finger proximal to distal inter-phalangeal joint	100% digit
(d) If any of metacarpal is included in the amputation, the impairment is rated to the amputation, the impairment is rated to the hand , and an additional 10% is added to digit value	10 % hand to digit value

(e) If two or more digits are amputated the impairments is rated as the hand, and includes the additional 10% of the hand given for each metacarpal loss

(E) Thumb Amputation

(a) 1/2 of distal phalanx	25% digit
(b) At interphalangeal joint	50% digit
(c) Proximal to interphalangeal jont	100% digit

(d) If any part of metacapal is included the impairment is related to the hand and an additional 10% of the hand is added to the value of the thumb (50% of hand)

F. Soft Tissue loss

Isolated soft tissue loss of the end of the digit should have a value up to 25% of digit

G. Sensory loss

(a) Complete loss of sensation (exclusive of tendon-damage) any digit or thumb

1. 1/2 of distal phalanx	25% digit
2. 1/2 of digit	50% digit
3. Whole digit	100% digit

(b) Partial loss of sensation

1. Digits (exclusive of thumb)

a. Radial half of digit
60% of values in G .(a) 1,2, or 3

b. Ulnar half of digit
40% of values in G. (a) 1,2, or 3

2. Thumb
a. Ulnar half of digit
60 % of values in G (a) 1,2, or 3

b. Radial half of digit
40% of values in G. (a) 1,2, or 3

DISABILITIES OF THE BACK

The following ratings for permanent impairment to the body in back injuries are suggested as reasonable and representative orthopaedic evaluations readily reconciled to the average specific award ratings specified by compensation statutes of various localities.

The permanent physical impairment can not be evaluated solely on limited motion. It must be judged on ability to carry out such functions as lifting. stooping, reaching , twisting and jumping. Pain is a major factor to its reality and its likelihood of permanency

CERVICAL SPINE	Per cent whole body permanent Physical Impairment and Loss of Physical function
1. Healed sprain , contusion	
A. No involuntary muscle spasm, subjective symptoms of pain not substantiated by demonstrable structural pathology	0
B. Persistent muscle spasm, rigidity and pain substantiated by loss of anterior curve revealed by x-ray , although no demonstrable structural pathology , moderate referred shoulder-arm pain	10
C. Same as (B) with gross degenerative change consisting of narrowing of intervertebral spaces and osteo arthritic lipping of vertebral margins	20
2. Fracture	
A. Vertebral compression 25% one or two vertebral adjacent bodies, no fragmentation no involvement , moderate neck rigidity and persistent soreness	20
B. Posterior elements with x-ray evidence of moderate partial dislocation	
(a) No nerve root involvement , healed	15
(b) With persistent pain, with mild motor and sensory manifestations	25
(c) with fusion, healed, no permanent motor or sensory changes	20
C. Severe dislocation, fair to good reduction with surgical fusion	
(a) No residual motor or sensory changes	25
(b) Poor reduction with fusion, persistent radicular pain, motor involvement , only slight weakness and numbness	35
(c) Same as (b) with partial paralysis , determine additional rating for loss of use of extremities and sphincters	

CERVICAL INTERVERTEBRAL DISC

1. Operative, successful removal of Disc, with relief of acute pain, no fusion , no neurologic residual	10
2. Same as (i) with neurological manifestations, persistent pain , numbness, weakness in fingers	20

THORACIC AND DORSOLUMBAR SPINE

1. Severe costo-vertebral construction or strain casually related to trauma with persistent pain moderate degenerative changes with osteoarthritic lipping, no x-ray evidence of structural trauma	10
2. Fracture	
A. Compression 25%, involving one or two vertebral bodies , mild, no fragmentation, healed, no neurological manifestations	10
B. Compressions 50% , with involvement posterior elements, healed, no neurologic manifestations, persistent pain, fusion indicated	20
C. Same as (B) with fusion, pain only on heavy use of back	20
D. Total paraplegia	100
E. Posterior elements, partial paralysis with or without fusion, should be tested for loss of use of extremities and sphincters	

LOW LUMBAR

1. Healed sprain, contusion	
A. No involuntary muscle spasm, subjective symptoms of pain not substantiated by demonstrable structural pathology	0
B. Persistent muscle spasm, rigidity and pain substantiated by demonstrable degenerative changes, moderate osteoarthritic lipping revealed by x-ray, combined trauma and per-existing factors	10
C. Same as (B) with more extensive osteoar - thritic lipping	15
D. Same as (B) with spondylolysis or spondy- lolisthesis Grade I or II, demonstrable by x-ray, without surgery, combined trauma and per-existing anomaly	20
E. Same as (D) with Grade III or IV spondylo-listhesis persistent pain, without fusion, aggravated by trauma	35
F. Same as (B) or (C) with fusion laminectomy pain moderated	25
2. Fracture	
A. Vertebral compression 25% one or two	

adjacent vertebral bodies, little or fragmentation, no definite pattern or neurologic changes 15

B. Compression with fragmentation posterior elements, persistent pain , weakness and stiffness, healed, no fusion, no lifting over 25 pounds 40

C. Same as (B) , healed with fusion , mild pain 25

D. Same as (C) , nerve root involvement to lower extremities, determine additional rating for loss of industrial function to extremities

E. same as (C) with fragmentation of posterior Elements, with persistent pain after fusion no neurologic findings 35

F. Same as (C) , with nerve root involvement to lower extremities, rate with functional loss to extremities

G. Total paraplegia 100

H. Posterior elements, partial paralysis with or without fusion, should be tested for loss of use of extremities and sphincters

3. Neurogenic Low Back Pain - Disk Injury

A. Periodic acute episodes with acute pain and persistent body list, tests for sciatic pain positive, temporary recovery 5 to 8 weeks 5

B. Surgical excision of disc, no fusion, good results, no persistent sciatic pain 10

C. Surgical excision of disc, no fusion moderate persistent pain and stiffness aggravated by heavy lifting with necessary modification of activities 20

D. Surgical excision of disc with fusion activities of lifting moderately modified 15

E. Surgical excision of disc with fusion, persistent pain and stiffness aggravated by heavy lifting, necessitating modification of all activities requiring heavy lifting 25

ANNEXURE X

SOUTH EASTERN RAILWAY

MEDICAL DEPARTMENT

WORKMEN'S COMPENSATION ACT

MEDICAL CERTIFICATE OF ASSESSMENT OF PERCENTAGE OF LOSS OF EARNING CAPACITY.

This is to certify that Shri _____ Designation _____

Staff No. _____ Department _____ Sustained injury in an accident covered

by the Workmen's Compensation Act on _____ (date) as a result of which he has

* lost _____ _____

* lost the use of

The loss of earning capacity in this case is assessed at _____

percent of earning capacity for this permanent * total / partial disablement.

Date: _____ Railway doctor Signature : _____

Place: _____ Designation: _____

* Delete whichever is inapplicable.

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