

CLAIMS No.....

WORKMEN'S COMPENSATION-NOTICE OF INJURY FORM

Particulars of Accident to be furnished by the Employer

Answering these questions does not imply that the Employer admit liability or that the Workman will make a claim

The Employer		
Name		
Address... ..		Phone No.
Trade or Business		
Policy No.		Have you any } Power-driven machinery? }
Date of payment of last premium		
THE INJURED PERSON		
1. Name and Age		Age
Address		
Married or Singles		Nationality
Normal occupation		Period in your service
2. Is he/she in your direct employ? if not, give name and address of Contractor		
3. Date of payment of last premium		
4. State fully the work upon which he/she was engaged at the time of the accident		
5. State on the back of this form the earning during the past 12 months.		
THE ACCIDENT		Date 20 time
6. Date, time and place		Place
7. Date the injured person ceased work		
8. How did the accident occur?		
9. When and to whom did he/she first report the accident		
10. State fully the nature of the injuries. If accident happened in connection with any machinery, give name of machine and state part causing accident		
11. State names of any witnesses		
12. Did the injury result in death? If so state date		
13. Was he/she under the influence of drugs or drink or was he/she guilty of any misconduct or breach of orders or rules? If so, please explain fully.		
14. Was the accident due to anyone's negligence? If so, give particulars		
15. Is he/she able to perform any part of his/her duties		
16. What is the probable period of disablement, in your opinion?		

I/We certify that the above and the wages statement overleaf are true to the best of our/my knowledge and belief.

Employer's signature

Date 19 Occupation

N.B.-The wages Statement overleaf should be completed if a claim has been, or is likely to be made.

WAGES STATEMENT

WAGES STATEMENT, and (if supplied by the Employer), the value of **FOOD, FUEL, and QUARTERS** and other prerequisites.

Complete on monthly or weekly bases, ignoring whichever of the first two columns is not applicable.

If paid monthly MONTHLY ENDING	If paid weekly WEEK ENDING	CASH WAGES	Value of Food, Fuel and quarters, and other perquisites	Dates of any absences from work and reasons for absence
1	1 2			
2	3 4			
3	5 6			
4	7 8			
5	9 10			
6	11 12			
7	13 14			
8	15 16			
9	17 18			
10	19 20			
11	21 22			
12	23 24			
TOTAL ON MONTHLY BASIS				
	25			
	26			
	27			
	28			
	29			
	30			
	31			
	32			
	33			
	34			
	35			
	36			
	37			
	38			
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	48			
	49			
	50			
	51			
	52			
	TOTALS ON WEEKLY BASIS			

THE OBJECT OF THIS FORM IS TO ASCERTAIN THE EXACT AVERAGE EARNINGS OF THE INJURED PERSON. IT SHOULD BE CAREFULLY COMPLETED GIVING THE FIGURES REQUIRED FOR THE TWELVE MONTHS PRIOR TO THE ACCIDENT OF FOR SUCH SHORTER PERIOD AS HE/SHE MAY HAVE BEEN IN YOUR SERVICE