Employer's Liability Accident Report Form

WHEN AN ACCIDENT CAUSES DEATH OR WHERE THE NATURE OF THE INJURY WILL OBVIOUSLY ENTAIL A DISABILITY EXCEEDING THREE DAYS THE FORMS SHOULD BE DISPATCHED IMMEDIATELY TO THE ABOVE ADDRESS.

In fatal accidents the Company should be notified immediately by telephone or facsimile so that representation at the enquiry into the death can be arranged.

In respect of minor injuries no report need be sent unless the period of disability exceeds three days or a claim is made.

No payment, offer or promise of any payment or admission of liability in any way should be made.

1: Name of Policy holder:

Policy Number:

Address:

Date and Time of Accident:

2: Date Work Ceased: / /

3: Place of Accident:

DATE OF BIRTH

SURNAME **FORENAME(S)**

4: Details of Injured Person:

5: Address:

6: Occupation:

7: Nature of Injury or Disease:

8: State precisely the cause of the Injury or Disease:

9: If an Accident, was it caused by a person not in your employment? If so state:

Name:

Address:

Name and address of such person's Employer:

10: Name of Foreman in Charge:

11: Witnesses name and address:

Date: Signature of Official: