THE NATIONAL INSURANCE BOARD

EMPLOYER'S REPORT ON ACCIDENT AT WORK

INSTRUCTIONS FOR COMPLETING THIS FORM

1. National Insurance Regulations require that all accidents be reported to the employer. The employer must investigate every accident that comes to his attention, before the form is completed.
2. The entire form is to be completed by the employer or his agent.
3. All questions are to be answered fully; otherwise the form would be incomplete.
4. Submit the form immediately or within three (3) months from date of accident to the nearest National Insurance Local Office, to avoid delay in the processing of the claim and possible penalty (fine of $500.00) to the employer.

BUSINESS NAME: _____ REGISRATION No.: _____

ADDRESS: _____ P.O. Box: _____ TELEPHONE NUMBER: _____

NATURE OF INDUSTRY OR BUSINESS: _____

SECTION A: CLAIMANT'S NATIONAL INSURANCE NUMBER: | | | | | | | | |

Full Name of Employee: _____

Address: _____ Occupation: _____

Date of Accident: _____ Time: _____ A.M. _____ P.M.

Place of Accident: _____

Nature of Incapacity/Injury: _____

SECTION B:

1. Was the person: [a.] Employed by you on the day of the accident: [ ] Yes [ ] No
   [b.] A Partner, Director or Sub-contractor [ ] Yes [ ] No
   [c.] Involved in an accident that took place while working on the date mentioned in Section A. [ ] Yes [ ] No
2. Between what hours was the person expected to work that day? From ____ A.M/P.M To: ____ A.M/P.M
3. Was the accident reported to you or a responsible person in your service? [ ] Yes [ ] No
4. If the accident was not reported on the day it happened, state why : _____

_____

5. When was the accident first reported? Date _____ Time: _____ A.M/P.M
6. What was the Employee doing at the time of the accident, and how was the task related to his duties?

_____

7. Describe how the accident happened? _____

_____

_____

8. What are the duties of the Employee? _____

_____

9. Was the Employee authorised to be in that place at that time for the purpose of his/her work? [ ] Yes [ ] No

10. What injuries were observed at the time of the accident? _____

_____

11. What additional injuries, if any, have been reported which were not observed at the time of the accident?

_____

12. Did the injured person continue to work after reporting the accident on that day? [ ] Yes [ ] No

13. Last day Employee worked: [ ] [ ] [ ]
Day *Month* *Year*

14. Did Employee return to work? [ ] Yes [ ] No
If "yes", date employee returned to work: [ ] [ ] [ ]
Day *Month* *Year*

15. Are you satisfied, as a result of your investigation, that an accident ocurred at the time, date and place as stated?
[ ] Yes [ ] No

16. Please give details of any discrepancy found between the information reported at the time, and the particulars revealed by your investigations. _____

_____

_____

17. Were there any witnesses to the accident? [ ] Yes [ ] No
Please state the witness' name(s) and have witness produce statement to be attached to this report.

Name: _____ Name: _____
Address: _____ Address: _____
Telephone Number: _____ Telephone Number: _____

18. What health and safety measures have the Employer taken to minimize or prevent the reoccurrence of an accident of this nature? _____

_____

_____

PLEASE NOTE: Any person who, for the purpose of obtaining a benefit under the National Insurance Act (Chapter 350 Section 52[5]) either for himself or for some other person, makes any false statement or false representation, or produces any false documents, etc., shall be liable on summary conviction to a fine not exceeding $2,500.00, or to imprisonment for up to twelve(12) months or both.

DECLARATION:
I state that the information given on this form is true and correct to the best of my knowledge.

Signature: _____ Print Name: _____
Date: _____ Position at Firm/Company: _____