



SOCIAL SECURITY BOARD
EMPLOYMENT INJURY ACCIDENT REPORT

(This form must be completed by the Employer)

KINDLY PRESENT DETAILED INFORMATION

NAME OF EMPLOYER: _____

MAILING ADDRESS: _____

TYPE OF BUSINESS: _____

EMPLOYER REGISTRATION NO: _____ TELEPHONE NO: _____

NAME OF EMPLOYEE: _____

MAILING ADDRESS: _____

SOCIAL SECURITY NO: _____ DATE OF BIRTH: ___/___/___

OCCUPATION: _____

DATE OF ACCIDENT: _____ TIME ___ A.M. ___ P.M. ___

DATE ACCIDENT OCCUR DURING WORK HOURS _____

DATE ACCIDENT REPORTED TO EMPLOYER _____

WAS EMPLOYEE ENGAGED IN HIS/HER NORMAL AT THE TIME OF THE ACCIDENT?

IF NO, WHAT WAS THE PURPOSE FOR BEING AT THE PLACE OF THE ACCIDENT?

FULL ADDRESS OF PREMISES WHERE ACCIDENT OCCURED: _____

NATURE AND EXTENT OF INJURIES: _____

WHERE WAS THE INJURED EMPLOYEE TAKEN: _____

DID THE PERSON WORK DURING THE INJURY PERIOD: _____

IF YES, STATE PERIOD _____

