NOTIFICATION OF ACCIDENT FORM - WORKMEN'S COMPENSATION INSURANCE

Answering these questions does not imply that the Employer admits liability, or that the workmen will make a claim.

**PARTICULARS OF ACCIDENT**

1. Employer's Name: ____________________________ Policy No.: ____________________________
   Business: ____________________________ Phone No.: ____________________________
   Address: ____________________________

2. Workman's Name: ____________________________ Occupation: ____________________________
   Address: ____________________________

3. State the age of the workman: ________ How long has been in your employ: ________
   His weekly wages at the time of accident: ________
   His average weekly earnings for the previous 12 months or shorter employ: ________

4. Was he/she in your employ and actually doing work for you at the time the accident occurred? If not, please give the name and address of the person by whom he/she was employed. ________

5. The accident occurred at ________ on the day of ________ 19 and the disability commenced on the day of ________ 19 at ________

6. When was the accident first reported to you? ________

7. Describe what WORK the injured person was doing at the time and how the accident actually occurred. ________

8. State the nature and extent of the injuries. ________

9. State whether employee is left or right handed ________

10. Has the injured person been treated at a Hospital? ________
    If so, give date of admission and discharge ________

11. Give the name of any witness of the accident. ________

12. Is the Workman now doing any work. If so, on what date did he start? ________
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<th>Question</th>
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<td>13</td>
<td>How much longer is the Workmann likely to be disabled?</td>
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<td>14</td>
<td>Name of Doctor in attendance.</td>
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<td>15</td>
<td>What is the motive power of the machinery used on your premises?</td>
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<td>How many employees have you?</td>
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Signature: ___________________________  Date: ___________________________
