



EMPLOYER'S LIABILITY ACCIDENT REPORT FORM

1 THE INSURED			
Policy Number:		Claim Number:	
Employer's Name:			
Policy Holder Details:			
Address:			
Parish:		Occupation:	
Business:		Telephone Number:	
2 ACCIDENT DETAILS			
Date of Accident:		Time of Accident:	
Place of Accident:			
When was the accident first reported to you?			
Who reported the accident?			
Names of Witnesses:			
3 DETAILS OF PERSON INJURED			
Name of injured person:			
Date of Birth:	Age:	Married () Single ()	
Occupation:			
House/Lot #:		Road/Avenue:	
Area in PA:	Parish Area:	Parish:	
Where is the injured person at present?			
Does the injured reside with you? Yes () No ()			
Relationship to Employer (if any):			
When did the injured enter your service?			
Is the injured person in your regular employment? Yes () No ()			
Was the injured in your direct employ, or in that of a sub-contractor? Direct Employ () Sub-contractor (). If sub-contractor, please state the name and address of the sub-contractor.			
Name of sub-contractor:			
House/Lot #:		Road/Avenue:	
Area in PA:	Parish Area:	Parish:	
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(i) State precisely what the injured was doing, and how the accident occurred. (If the accident was due to any defect in machinery, scaffolding, or other equipment, state nature thereof).			

(ii) Was the injured performing a duty for which the injured was employed?

(iii) Was the injured disobeying any rule or order?

(iv) Who was in charge?

(v) Was the accident due to another person's negligence? Yes () No (). If so, please give particulars.

5. NATURE OF INJURY

Nature and extent of injury. If to arm or hand, state whether right or left.

6. WORK ABILITY

Did the injured stop work immediately? Yes () No (). If not, when did the injured stop?
Date: _____ **Time:** _____

If taken to a hospital, state which and whether as an in-patient or outpatient.
Hospital: _____
In-patient () Out-patient ()

Is the injured disabled now? Yes () No (). If not, when did the injured resume work?
Probable further duration of disablement.

7. ADDITIONAL ACCIDENT DETAILS

Is there any other information regarding the accident or the injured person with which the company should be acquainted?

B.	OTHER INSURANCE
(1) Have you any other insurance or indemnity covering accidents to your employees? Yes () No (). If so, please give particulars.	
Date: _____	Employer's Signature: _____

