POWELL
COMMERCIAL LTD
INSURANCE BROKERS

EMPLOYERS LIABILITY ACCIDENT REPORT FORM

THE EMPLOYER

Name | Business

Address | Telephone

Broker

Policy Number | Date policy commenced

VAT registered Yes ☐ No ☐ | VAT registration number

THE INJURED PERSON

Name | Occupation

Address | Telephone

Age | Date of Birth | National Insurance number

Marital Status | Date employment commenced

Address of local DHSS office

Direct employee Yes ☐ No ☐ | If No - Name of Employer

Address of Employer

Business of Employer

THE ACCIDENT

Date of Accident | Time of accident

Location of accident

Circumstances of accident

Cause of accident

Was machinery or plant involved — Yes ☐ No ☐

Is the broken part of the machinery/plant being retained? — Yes ☐ No ☐

If 'Yes' describe

When and to whom was the accident first reported — Time | Date | To

Names and addresses of witnesses to the accident

Date and time injured person ceased work due to accident — Date | Time

Name of injured person's immediate supervisor

Job Title

THE INJURY

The injury sustained

Hospital attended — Yes ☐ No ☐ Injured person detained in hospital — Yes ☐ No ☐

If 'Yes' - Name of Hospital

Address of Hospital

If 'Yes' - when released

GENERAL

Has the injured person resumed work? — Yes ☐ No ☐ If 'Yes' - when?

On resuming work, was normal work taken up? — Yes ☐ No ☐

Net earnings of injured person to date of accident

In which week of the tax year did accident occur

Should further information be required by Loss Adjusters or should the Loss Adjusters wish to investigate fully the accident, whom should the Loss Adjusters contact? — Name | Designation

I/We certify that the foregoing is a true account to the best of my/our knowledge and belief

Signature of Employer | Date

PLEASE ATTACH TO THIS CLAIM FORM A COPY OF ANY OFFICIAL ACCIDENT BOOK ENTRY TOGETHER WITH ANY OTHER INVESTIGATION REPORTS THAT MAY BE AVAILABLE IN RELATION TO THIS INCIDENT.