INDUSTRIAL ACCIDENT BOARD
STATE OF DELAWARE

STATEMENT OF FACTS

Delaware's law requires every Employee alleging an injury at work to complete ALL information on this form for his Employer. The Employee must also sign, date and return this form after its completion.

1. **Employee**: _____

   Address: _____

   City: _____ **State**: _____ **Zip**: _____

   Telephone No.: _____ **E-mail (optional)**: _____

2. **Date of Accident**: _____
3. **Place of Accident**: _____
4. **Employer**: _____

   Employer Contact: _____ **E-mail (optional)**: _____

   Address: _____

   City: _____ **State**: _____ **Zip**: _____

   Telephone No.: _____ **Fax No.**: _____
5. **Name of Insurance Carrier / Third Party Administrator**: _____
6. **Occupation of Employee at the time of accident**: _____
7. **Describe the ACCIDENT and how it happened (attach new sheet if more space needed):**

   _____

   _____
8. **Describe the NATURE OF INJURY / list the INJURED BODY PARTS (attach new sheet if more space needed):**

   _____

   _____
9. **Did Employee receive medical, surgical or hospital service**: YES ☐ NO ☐
10. **When was notice of injury given to or received by Employer**: _____
11. **Give names & addresses of all employers in PAST 5 YEARS (attach new sheet if more space needed):**

NAME:	ADDRESS:
_____	_____
_____	_____
_____	_____
_____	_____

12. **State Employee's average weekly wage when injured**: _____
13. **State name & address of every treating doctor in THIS CLAIM (attach new sheet if more space needed):**

NAME:	ADDRESS:
_____	_____
_____	_____
_____	_____
_____	_____

14. Name & address of every treating doctor in LAST 10 YEARS (attach new sheet if more space needed):

NAME:	ADDRESS:

15. Names, addresses & dates of treatment of all hospitals & institutes treating for THIS INJURY (attach new sheet if more space needed):

NAME:	ADDRESS:	DATES:

16. To what extent did injury prevent employee from working and for how long:

_____

_____

17. State whether or not Employee has fully recovered and if only partially to what extent:

_____

_____

18. Has Employee resumed work: YES ☐ NO ☐

a. If YES: State when and give name of present Employer:

_____

b. If YES: State what trade or occupation and weekly wages:

_____

c. If NO: State how long likely to be incapacitated from resuming work:

_____

19. Identify, describe and give dates of all PREVIOUS and SUBSEQUENT INJURIES:

_____

_____

_____

_____

20. State any other important facts bearing on the claim above presented:

_____

_____

_____

DATED THIS _____ DAY OF _____, A.D._____

_____

EMPLOYEE SIGNATURE