FORM 2

Industrial Accident Board
Office of Workers' Compensation
4425 N. Market Street; 3rd Floor
Wilmington, DE 19802
Telephone (302) 761-8200

# STATE OF DELAWARE
# EMPLOYER'S SUPPLEMENTAL REPORT OF INJURY OR DISEASE

I.A.B. FILE No.

EMPLOYER'S F.E.I.N.

If Employer's First Report of Injury did not show that the injured employee had returned to work, an Employer's Supplemental Report of Injury should be completed and filed immediately after return to work of the employee; or at the end of disability when compensation has been paid under an Agreement. In the event of the death of the employee, this report should be filed immediately.

**1.** Name of Employer: _____

**2.** Employer's Address: _____

**3.** Insurance Co. Name: _____

**4.** Name of Injured (in full): _____

**5.** Injured's present address: _____

**6.** Date of the Injury: _____ Day of Week: _____ Time: _____

**7.** Date disability began: _____ Day of Week: _____ Time: _____

**8.** Did Injured return to work: **YES:** ☐ **NO:** ☐ If so, date and time: _____

**9.** At same wages as before: **YES:** ☐ **NO:** ☐ If not, explain: _____

**10.** If disability has not terminated, state probable date of termination of disability: _____

**11.** Has the Injured died: **YES:** ☐ **NO:** ☐ If so, date of death: _____

**12.** State if there is any scheduled loss, loss of function or facial disfigurement:* **YES:** ☐ **NO:** ☐ **SEE RPT:** ☐

**13.** Employer, provide any other comments or remarks below:

_____
**EMPLOYER OR INSURER SIGNATURE**

* *Question 12 is unnecessary where the final report of the surgeon or physician is filed with the Board.*

Date of Report: _____ Firm Name: _____

Form signed by: _____ Official Title: _____