INDUSTRIAL ACCIDENT BOARD
STATE OF DELAWARE

STATEMENT OF FACTS

The Industrial Accident Board requires every Employee alleging an injury at work to complete ALL information on this form for his Employer. The Employee shall also sign, date and return this form to his Employer after its completion.

1. **Name of Employee**: _____

   Address: _____

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

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

2. **Date of Accident**: _____

3. **Place of Accident**: _____

4. **Name of 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 a separate sheet if more space needed):**

   _____

   _____

8. **Describe the NATURE OF INJURY to the INJURED BODY PARTS (attach a separate 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 and addresses of all employers in PAST 5 YEARS (attach a separate sheet if more space needed):**

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

12. **State Employee's average weekly wage when injured**: _____

13. **State name and address of every treating doctor in THIS CLAIM (attach a separate sheet if more space needed):**

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

14. Give names and addresses of every treating doctor in LAST 10 YEARS (attach a separate sheet if more space needed):

NAME:	ADDRESS:

15. Give names, addresses and dates of treatment of all hospitals and institutes treating for THIS INJURY (attach a separate 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 Employee has fully recovered or partially recovered. If only partially, state 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