

**INDUSTRIAL ACCIDENT BOARD
STATE OF DELAWARE**

STATEMENT OF FACTS

The Industrial Accident Board requires the claimant who alleges the death of an Employee by an industrial accident to complete ALL information on this form, sign, date and return this form to the 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.: _____ **Facsimile 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. **Give names and addresses of every treating doctor in LAST 10 YEARS (attach a separate sheet if more space needed):**

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

14. State number of weeks employed during the last twelve months: _____

15. State at what trade or occupation employed during the last twelve months:

16. Date of Employee's death: _____

17. What were the expenses of last sickness and burial:

18. What amount of these expenses were paid by the Employer:

19. Name of widow or widower of deceased, if dependent:

20. Names and dates of birth of dependent children under sixteen years of age:
NAME: BIRTH DATE:

21. Names and addresses of surviving father and mother of deceased, if dependent:
NAME: ADDRESS:

22. Names and dates of birth of dependent siblings of deceased under sixteen years of age:
NAME: BIRTH DATE:

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

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

CLAIMANT SIGNATURE