INDUSTRIAL ACCIDENT BOARD
STATE OF DELAWARE

STATEMENT OF FACTS

The claimant alleging death of an employee by a work accident shall provide true and complete responses to all inquiries on this form. To verify its completeness and accuracy, the claimant shall sign, date and file this form with the petition.

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._____

I swear or affirm that the information contained in this statement is true and corect to the best of my knowledge and recollection. I understand and acknowledge that any falsehood contained in this statement may expose me to civil or criminal liability.

_____

DEPENDENT SIGNATURE