

**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 correct 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**