INDUSTRIAL ACCIDENT BOARD
STATE OF DELAWARE

STATEMENT OF FACTS

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 / ILLNESS 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 all treating doctors 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:

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._____

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.

_____

EMPLOYEE SIGNATURE