

**INDUSTRIAL ACCIDENT BOARD
STATE OF DELAWARE**

STATEMENT OF FACTS

The employee alleging to have been injured at work shall provide true and complete responses to all inquiries on this form. To verify completeness and accuracy, the employee shall also sign and date this form and return it to his employer.

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