INDUSTRIAL ACCIDENT BOARD
4425 N. Market Street; 3rd Fl.
Wilmington, DE 19802
Telephone (302) 761-8200
Facsimile (302) 736-9170

STATE OF DELAWARE
EMPLOYER'S SUPPLEMENTAL
REPORT OF INJURY OR DISEASE

I.A.B. FILE NO. _____

EMPLOYER'S F.E.I.N. _____

If Employer's First Report of Injury did not show that the injured employee had returned to work, an Employer's Supplemental Report of Injury should be completed and filed immediately after return to work of the employee; or at the end of disability when compensation has been paid under an Agreement. This report should be filed periodically to keep the Board's file current and immediately in the event of the death of the employee.

1. Name of Employer: _____
2. Employer's Address: _____
3. Insurance Co. Name: _____
4. Name of Injured (in full): _____
5. Injured's present address: _____
6. Date of the Injury: _____ Day of Week: _____ Time: _____
7. Date disability began: _____ Day of Week: _____ Time: _____
8. Did Injured return to work: **YES:** ☐ **NO:** ☐ If so, date and time: _____
9. At same wages as before: **YES:** ☐ **NO:** ☐ If not, explain: _____
10. If disability has not terminated, state probable date of termination of disability: _____
11. State if the Injured died: **YES:** ☐ **NO:** ☐ If so, date of death: _____
12. State if there is any loss, loss of use, disfigurement or an accepted surgery:* **YES:** ☐ **NO:** ☐ **SEE REPORT:** ☐
13. Employer, use below to provide any other comments, remarks or updates:

_____
EMPLOYER'S AUTHORIZED AGENT

Date of Report: _____ Firm Name: _____

Form signed by: _____ Official Title: _____

* *Question 12 is unnecessary where the final report of the surgeon or physician is filed with the Board.*