FORM 2

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. In the event of the death of the employee, this report should be filed immediately.

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 surgery accepted:* **YES:** ☐ **NO:** ☐ **SEE RPT:** ☐

13. Employer, use below to provide any other comments, remarks or updates:

_____
EMPLOYER'S AUTHORIZED AGENT

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

Date of Report: _____ Firm Name: _____

Form signed by: _____ Official Title: _____