Background pattern

Description automatically generated with low confidence

**EMPLOYER’S LIABILITY ACCIDENT REPORT FORM**

In the event of a claim, please notify your insurance broker.

Policy Number: Name of Insured: Address:

Postcode: Telephone No: Contact Name: Telephone No:

Name of Employee: Address:

Postcode: Date of Birth: Occupation: National Insurance No:

Date of Accident: Time of Accident: Place of Accident: Nature of injury or disease: Date ceased work: Date returned to work:

Circumstances of accident/disease (if necessary, please continue overleaf):

Was the accident/disease caused by any other party? If yes, please provide details: Yes No

In addition to the accident description please also provide copies of:

* Your Accident Book Entry • Any Statutory Health & Safety Notification • Any internal investigation report Name of Foreman/Supervisor: Name and address of Witnesses: Signature of Official: Date: