

WORKER'S COMPENSATION CLAIM FORM

Name of Employer: _____

1. Address of Employer: _____

2. Injured Person(s) Name: _____

3. Injured Person(s) Job Title (description of usual duties): _____

4. Date of accident: _____

5. Where did the accident occur?: _____

6. Date and to whom accident was reported?: _____

7. a) At what time did the accident occur?: _____

b) Was the Injured Person(s) acting in the course of his employment at the time of the accident?: _____

8. How did the accident occur?: _____

9. Statement from witness(es) (attach separate sheet if necessary):

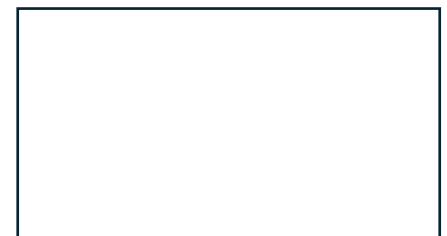
10. Nature of injury (note that forms BL43/02, BL43/03, BL43/04B & BL43/10 must accompany this claim form)

11. Steps taken to prevent a re-occurrence: _____

Thereby warrant the truth of the above statements

Manager's Signature: _____

Date: _____



Company Stamp: